

The implementation of good practice in school-based drug education: a stakeholder evaluation

Nicola Drucquer

**Submitted in partial fulfilment of the award of the Degree of Doctor of
Philosophy (PhD) De Montfort University**

June 2005

ABSTRACT

This thesis analyses the delivery of drug education in the school setting through an exploration of the views, experiences and actions of two key stakeholders in the process: teachers with responsibility for programme co-ordination and development and pupils in the 15-16 year old age group. It is based on mixed methodology research carried out in schools in the East Midlands of England (1997-1999) and is inspired by post-positivist evaluation paradigms. Drawing on theories and models from sociology, psychology (communication theory), policy studies and health education, the thesis promotes understanding of factors helping and hindering the implementation of principles of good practice in drug education. The main reasons for a discrepancy between 'ideals' and chalk face realities emerge as timetable constraints, a lack of confident and skilled delivery teachers and uncertainty in relation to the acceptability of a harm-reduction focus to programmes. Implicated, on a deeper level, are the dominant values in the education system and the ideology behind current drug control policy. The thesis develops a conceptual schema that captures the personal, interpersonal, organisational and wider, contextual influences behind patterns of variability in young people's take-up of drug education messages and indicates how these interrelate. It also sets out an argument that the key to efficacy in drug education lies in the sensitive tailoring of programmes to the pre-dispositions that young people bring to the process. The thesis concludes with recommendations for the future enhancement of policy and practice in this area.

CONTENTS

List of tables	i
List of figures	iii
List of abbreviations and acronyms	iv
Acknowledgements	v
Preface	vi
Introduction	1
Analytical focus and definition of terms	1
Purpose and structure of study	4
1) Drug education in schools: background and policy framework	7
1.1 Historical background	8
1.2 The framework for health education in schools (mid to late 90s)	16
1.3 Conclusions	30
2) Theoretical issues in the evaluation of school-based drug education	32
2.1 The overall evaluation approach	32
2.2 The conceptual and analytical framework	41
2.3 Provisional schema of influences on the processes of drug education delivery	77
2.4 The research questions	83
3) Methodology	84
3.1 The research methods	84
3.2 The research strategy	94
3.3 Limitations of the methodology	108
4) Variations in programme delivery and impact	113
4.1 Findings from the survey of pupils	114
4.2 Findings from the survey of drug education co-ordinators	131
4.3 Findings based on documentary data from the case study schools	140
4.4 Conclusions	147
5) Drug education reception: the pupils' perspectives	150
5.1 Factors affecting pupils' subjective dispositions to drug education	150

5.2	Pupils' views about programme shortcomings	179
5.3	Summary of key findings	196
5.4	Discussions and conclusions	198
6)	Teachers' perspectives on the delivery of drug education in schools	208
6.1	Understandings about principles of good drug education	209
6.2	Factors shaping delivery practices in institutional contexts	219
6.3	Summary of key findings	241
6.4	Discussion and conclusions	243
7)	Theoretical insights	247
7.1	Background to the provisional schema	247
7.2	Confirmed aspects of the provisional schema	250
7.3	Revisions to the provisional schema	254
7.4	The modified schema	256
7.5	Two contrasting implementation scenarios	259
8)	Conclusion	262
8.1	Resume of previous chapters	262
8.2	Recap of the methodological limitations	265
8.3	Contribution to knowledge	267
8.4	Implications of the findings and associated recommendations	271
	Appendices	286
1	Principles of drug education in schools: DfE (1995a)	287
2	Key principles of drug education: DfES (2004a)	290
3	Profile of the 12 survey schools	292
4a	Health-related attitudes and behaviour questionnaire	296
4b	Focus group schedule (pupils)	300
4c	Interview administration procedure	302
4d	Survey of drug education co-ordinators: questionnaire	303
4e	Interview schedule (teachers)	305
	References	306

LIST OF TABLES

Table 4.1	Impact of potential sources of influence on pupils' attitudes towards risk taking: a ranking to reflect power of influence	114
Table 4.2	Assessment of health education's impact on willingness to take health risk by gender	115
Table 4.3	Assessment of health education's impact on willingness to take health risk by ethnicity	116
Table 4.4	Category of Smoker	117
Table 4.5	Category of Drinker	118
Table 4.6	Frequency of getting drunk	119
Table 4.7	Use of illicit substances	120
Table 4.8	Assessment of health education's impact on willingness to take health risk by smoking category	121
Table 4.9	Smoking by sex and ethnic sub-group	122
Table 4.10	Assessment of health education's impact on willingness to take health risk by drunkenness	123
Table 4.11	Drinking by sex and ethnic group	124
Table 4.12	Drunkenness by sex and ethnic group	125
Table 4.13	Assessment of health education's impact on willingness to take health risk by use of illegal drugs	126
Table 4.14	Illicit drug use by sex and ethnic sub-group	127
Table 4.15	Assessment of health education's impact on willingness to take risk by model of curriculum delivery at school-level	128
Table 4.16	Assessment of health education's impact on willingness to take risk by ethnic profile of school	130
Table 4.17	Level of policy development	132
Table 4.18	Status of drug co-ordinator	133

Table 4.19	Location of drug education in the curriculum	134
Table 4.20	Proportion of staff who have had drug education training	135
Table 4.21	Opinions about conformity with good practice	136
Table 4.22	Programme aims	141
Table 4.23	The organisation of drug education	143
Table 4.24	Overall programme plan	144
Table 4.25	Teaching approaches	146

LIST OF FIGURES

Fig 1.1	WHO criteria for a health-promoting school	18
Fig 2.1	Lewis and Flynn's model of implementation	50
Fig 2.2	Beattie's structural analysis of health promotion approaches	53
Fig 2.3	The health action model: an overview	69
Fig 2.4	Provisional schema of influences on the delivery of school-based drug education	78
Fig 3.1	Methods and scheduling of data collection	86
Fig 3.2	Organisation of drug education in the case study schools: a summary of approach	93
Fig 7.1	Modified schema of influences on the delivery of school-based drug education	257
Fig 7.2	Scenario supportive to positive development in drug education provision	260
Fig 7.3	Scenario prejudicial to positive development in drug education provision	261

LIST OF ABBREVIATIONS AND ACRONYMS

ACMD	Advisory Council for the Misuse of Drugs
DfE	Department for Education
DfES	Department for Education and Skills
DfEE	Department for Education and Employment
DH	Department for Health
INSET	In-service Education and Training
ISDD	Institute for the Study of Drug Dependency
HAD	Health Development Agency
HEC	Health Education Council
LEA	Local Education Authority
OFSTED	Office for Standards in Education
PE	Physical Education
PSHE	Personal, Social and Health Education
RE	Religious Education
QCA	Qualifications and Curriculum Authority
SCODA	Standing Conference on Drugs and Alcohol
TACADE	Teachers Advisory Council for Alcohol and Drug Education
WHO	World Health Organisation

ACKNOWLEDGEMENTS

I would like to express my gratitude to my excellent supervisors Professor Denscombe and Professor Lowndes. Thank you Martyn, for your patience, the example you set me as a researcher and for all your constructive feedback over the last seven years. Thank you Vivien, for your inspiration and the painstaking help you have given me as second supervisor since the summer of 2003.

I would also like to acknowledge Rob Baggott for his useful advice and to warmly thank Derek Layder for a number of constructive conversations.

Thanks are due to my colleagues in Division of Health Studies – especially to Kathie Moore and Annie Peel.

Very importantly I would like to acknowledge Mike Drucquer for his emotional support and all his practical help in the domestic sphere. Lastly, I would like to say a big ‘thank you’ to Claire, Amy and Kate - for putting up with my lapses and for providing such an enjoyable alternative to work and study.

PREFACE

This thesis focuses on school-based drug education, a health promotion intervention that has long been a part – albeit a rather minor one – of the effort to combat the problem of substance misuse in the UK. My interest in the *practice* of drug education stems from my work experience in this sector prior to moving into academia. As an NHS employed health promotion specialist, I was involved in the training and support of teachers with responsibility for the co-ordination and delivery of health education in schools. This contact persuaded me that this group of professionals share a strong commitment to the type of sensitive and student-centred approaches now widely acknowledged as the basis of effective provision. However, in contrast, my professional and personal contact with young people suggested that this important section of the population tend to be negative about experiences of drug education in secondary school.

In 1996 I took up as a post as researcher on an ESRC project to investigate the impact of critical incidents on young people's health-related risk taking and this provided me with an opportunity to explore the factors and processes underlying this seeming discrepancy between enlightened intentions and the actual practice of drug education on the ground. From a public policy point of view the start of my research was well timed. Comprehensive programmes of drug education in schools were a central element of the Major government's *Tackling Drugs Together* strategy (Cm 2846, 1995). Consequently there was interest at both national and local authority-level in the quantity and quality of drug education in schools, and a need for research that could furnish decision makers with

insight into factors helping and hindering the implementation of agreed-on principles of good practice.

The findings that relate to pupils' reception of drug education are based on data collected under the auspices of the ESRC project. Apart from the lead researcher, Professor Martyn Denscombe, I was the only researcher involved with this project. As such, I was responsible for two thirds of the data collected through interviews and focus groups, and was actively involved with the analysis of both qualitative and quantitative data. Where material in the thesis is derived from joint interpretation and analysis of the ESRC data this is made clear at the specific point in the text. The findings that relate to the negotiation, planning and implementation of drug education programmes at school level are based on data that was collected and analysed entirely independently of the critical incidents research.

INTRODUCTION

Analytic focus and definitions of terms

This thesis analyses the processes underlying the delivery of drug education programmes in the school setting. This health promotion intervention is a key part of national drug control strategy, particularly the element that relates to the protection of young people from the dangers of drug misuse (Cm 3945, 1998). It is also allied to the public health drive to combat smoking and tackle alcohol misuse in the UK (Cm 4177, 1998; DH, 2004).

The thesis is based on research carried out in schools in the East Midlands of England and focuses on two groups with a key stake in the drug education process: pupils and teachers. 15-16 year old (Year 11) pupils were considered to be particularly interesting subjects for research on the basis of the relatively high levels of health-related risk taking within this section of the youth population (Plant and Plant, 1992). The views and experiences of the young people were elicited by a combination of quantitative and qualitative methods. A large-scale survey (n=1648) of 12 schools chosen to be representative of the area as a whole was followed up by a series of focus groups and interviews. On the basis of a research interest in the organisation of delivery, the research focussed upon teachers with responsibility for the co-ordination and development of drug education programmes at school-level. The views of this group were obtained by means of a survey of all drug-education co-ordinators in the local area. A case study approach using a sub-sample of the 12 schools then furnished more

in-depth insight into the processes and factors that shaped and determined delivery arrangements.

The fieldwork took place between 1997-1999, a period when the national framework for the delivery of drug education comprised official guidelines (DfE, 1995) against which schools were inspected. These guidelines promoted 'principles of good practice' based on widely accepted lessons distilled from over 30 years of research and practice in schools (Coggans and Watson, 1995; Ives and Clements, 1996; Allot, Paxton and Leonard, 1999). Most of this research was underpinned by a positivist evaluation paradigm that attaches value to 'hard proof' relating to outcomes. This approach has led to an accumulation of evidence concerning the relative merits of different drug education approaches (see Dorn and Murji 1992 for a classic review). As reviewers of such evidence are increasingly recognising, however, the omission of *process* from the analysis limits the practical utility of findings from traditionally framed studies (Oakley and Fullerton, 1995; Parsons et al, 1995; Lynagh et al, 1997; White and Pitts, 1997).

This thesis sets out to make a conceptual and empirical contribution to understanding of the negotiation, planning, implementation and reception of schools-based programmes of drug education. It develops an analytical framework that draws together research, theories and models that have not been hitherto combined. These theoretical materials are derived from sociology, social psychology (communication studies), policy studies and health education and give the study an interdisciplinary identity. The great advantage of an interdisciplinary approach is that it provides a wide analytical scope

and a richer comparative context than is the case with studies relying on a single discipline for their theoretical anchorage.

Before considering the main purpose and structure of the thesis it is necessary to clarify the way that certain key terms are being interpreted. In keeping with an important new element of the framework surrounding the delivery of drug education at national level - the National Healthy School Standard (DfEE, 1999) – ‘drug education’ is taken to refer to substances including alcohol and tobacco and the following categories of drugs:

- Prescribed and non-prescribed medication including anabolic steroids
- Solvents and volatile substances
- Illegal drugs, such as cannabis and ecstasy, controlled by the 1971 Misuse of Drugs Act

Where ‘schools’ are referred to this does not include pupil referral units. Pupils in such units are considered at high risk of substance-related harm and considered in need of individually targeted prevention programmes (DfES, 2004). In the drug education programmes investigated within this study, it was the assessment of group, as opposed to individual needs, that provided the basis for any customisation of the programme.

The terms ‘young people’ and ‘pupils’ are used interchangeably in the text. The latter term was chosen in preference to ‘student’ because it clearly denotes that the young subjects of the research were part of the school system.

Purpose and structure of the study

The purpose of the study is as follows:

To explore the processes underlying the delivery of school-based drug education programmes in order to account for factors that help and hinder the implementation of principles of good practice at the chalk face.

The thesis includes exploratory, descriptive, interpretive and explanatory elements and is organised in the following way:

Chapter 1 describes the background to, and policy framework surrounding the delivery of drug education in English schools. The contribution of evaluation studies to knowledge about what works best in drug education is highlighted as an important theme and offers a link to the next chapter.

Chapter 2 draws on the interpretivist and realist evaluation paradigms to establish the broad conceptual and methodological parameters for the research. Theoretical literature relevant to the implementation of good practice in drug education is reviewed and key concepts, suggestions and arguments are incorporated into a provisional schema. This conceptual schema then informs the identification of the research questions.

Chapter 3 establishes the compatibility of a mixed methodology research design with the research questions. It provides an account of, and a rationale for, the methodological strategies and approaches that characterise the empirical approach.

Chapter 4 presents and discusses findings from the study's two quantitative phases. The survey of pupils highlights gender and ethnicity-related difference in the impact of school-based health education on personal willingness to take risk. The key finding associated with the survey of teachers was that, different curriculum models notwithstanding, school-based drug education programmes are remarkably similar in terms of both content and the constraints upon them.

Chapter 5 presents and discusses findings concerning pupils' reactions to drug education input. The evidence identifies subjective and objective influences on pupils' receptivity to drug education messages, and emphasises the way that social and cultural milieu affect the pre-dispositions to health education arguments that individuals and groups of pupils bring with them to the chalk face. It also pinpoints specific obstacles to the uptake of health education arguments linked to the way that drug education delivery is organised and approached at school level.

Chapter 6 presents and discusses findings that relate to teachers' perspectives on the influences upon delivery-related decisions. The evidence shows that programme *intentions* were compatible with the principles of good drug education advocated and promoted at national level. It also highlights a range of factors that affect programme co-ordinators' scope to effect movement in the direction of good practice.

Chapter 7 revises the provisional conceptual schema in the light of the empirical findings. It endorses the principle that drug education should be sensitively tailored to the beliefs, interests and social experiences young people bring to interaction in the

classroom. The chapter then goes on to provide an original analysis based upon two ideal type scenarios: one favourable to the development of good practice in drug education at school level, the other prejudicial to this process.

Chapter 8 pulls the threads of the thesis together. It clarifies the original contribution of the thesis and presents a series of recommendations that draws out the implications of the findings for policy, practice and further research in the field of school-based drug education.

CHAPTER 1

DRUG EDUCATION IN SCHOOLS: BACKGROUND AND POLICY FRAMEWORK

This chapter provides a schematic historical background to the framework that currently surrounds the delivery of drug education in the school setting. This entails a consideration of the origins of drug education in moral instruction – an approach now formally rejected as inappropriate by the policy community, although still apparent in practice. It also includes a brief examination of the renaissance of drug education in the 1970s and 1980s, which provides the basis for the current state of knowledge about what works best in drug education. The main focus, however, is on the most recent history of policy development in the years immediately preceding the period 1997-1999, during which the field work for the thesis took place. Incremental changes to the delivery framework introduced by the New Labour Government after this period are not relevant to the analysis of this empirical data and, consequently, receive little attention in this chapter. However, chapter 8 examines the conclusions drawn from the data in the light of new policy directions.

The Chapter also serves as an introduction to the main themes, arguments and findings presented in subsequent chapters. In particular it draws attention to the importance of evaluation studies in assessing the efficacy of policy and practice in drug education.

Further, it spotlights the nature of underlying processes of drug education including programme planning, implementation and reception as well as the issues surrounding good practice, its feasibility and its delivery at the chalk face.

1.1 Historical background

The importance of the school as a setting for public health intervention receives acknowledgement in a number of leading texts in the field of health promotion. This chapter draws on chapters on the subject by Naidoo and Wells (2000) and Tones and Tilford (2001). It also acknowledges as a key resource a briefing paper on trends in the delivery of health education on drugs produced by the Institute for the Study of Drug Dependence (ISDD, 1984).

The origins of drug education

It is impossible to be certain about the earliest origins of health education on drugs. Historians have established that the use of psychoactive substances has characterised most societies and civilisations (Berridge, 1998; Davenport-Hines, 2001). Equally longstanding and widespread, it would appear, is the human and social impulse to protect population sub-groups perceived to be especially vulnerable from substance-related harm. Within this children and young people are a classic focus for concern. Research into the background of

current alcohol policy yields evidence that communication of ‘wisdom’ on the subject by elders is a tradition that dates back thousands of years (Musto, 1997).

This thesis is concerned with the communication of ‘wisdom’ on drugs within the formalized setting of schools and in this limited sense it is possible to be rather more precise on the question of origins. Against the backdrop of growth of the self-help movement in the late nineteenth century, a Christian-based temperance movement came into being. A key aim of this movement was the moral enlightenment of the population on the ‘evils’ of alcohol and in pursuit of its ends it used school premises as venues for talks designed to encourage the audience to join ranks with those already pledged to abstain (Baggott, 1990). The first example of a curriculum about temperance education was issued in 1909 by the Board of Education (cited in ISDD, 1984) and indicates that the earliest origins of school-based health education on drugs lie in moral instruction on the topic of drinking.

In the post-Second World War period sex education and parenthood education came to the fore as part of the government’s re-construction plans and provided a curriculum context for health education delivery. Guidance issued by one local education authority (LEA) conveys a flavour of the type of teaching pupils experienced in the 40s and 50s. This document encouraged schools to convey some understanding of how the body works, and to teach cookery and laundry work to girls in preparation for managing a home. It also suggested that, through scripture study, schools should encourage pupils to keep their

bodies 'in temperance, soberness and chastity' (Bristol Education Committee, 1944 - cited in Lewis, 1993).

In the 1960s a 'moral panic' over drug use increased the profile of health education on the subject in schools. Education was seen as an antidote to 'drug abuse' and led to the rise of a propagandist approach relying on the generation of fear (ISDD, 1984). This approach links with a **preventive model of health education approach**, as described in a classification system based on differing underlying philosophies originated by Tones (1981). The goal of this medically aligned model is to eradicate health risks at the individual level and it does so by using 'fair means or foul' to change or modify personal behaviours (Tones and Tilford, 2001: 11).

Analysis of teaching materials from the 1960s indicates that the sensationalism that characterised drug education lessons of the period was not limited to a focus on risks to physical health. Risks to social functioning were also exaggerated. This represents a strand of continuity with the earlier era and raises an issue that will recur as a theme: the legacy of drug education's roots in moral instruction on the modern-day practice of drug education. Films were a popular visual aid to lessons and tended to portray drug use as causing promiscuity in girls, lack of sexual interest in boys, or failure to take up the conventional sex-roles (work in the case of men, marriage in the case of women). The film 'Better Dead' provides a particularly good example of a resource designed to convey the message that drug use equates to a 'youthful perversion' (cited in ISDD, 1984).

The renaissance of health education on drugs

The 1970s and 1980s represented a renaissance period in which health education flourished and became a recognisable feature in the curriculum of most schools. From a narrower drug education perspective, the period also saw positive trends. Most notable of these was a shift away from the 'fire brigade' approach of giving drug education lectures and films on a one-off basis in response to evidence of drug experimentation, toward an attempt to integrate teaching about substances into broader health and social education curricula (ISDD, 1984).

Commentators are in agreement that these developments can be attributed to the impact of the concepts of progressivism - child-centredness, autonomy and developmental approach to learning – on the climate in the education system of the time (Sutherland, 1979; Lewis, 1993; Tones and Tilford, 2001). The same commentators also link them to the emergence of personal and social education (PSE) as a curriculum area and attach significance to the impact of curriculum development materials that began to move health education away from the prescriptive overtones of the past. Early projects such as the Schools Council Health Education Project 5-13 (1977) and Health Education Project (1982) saw health education as concerned with making informed decisions and the development of self esteem. Subsequent projects sought to develop social and life skills such as being assertive, making relationships, managing conflict, working in groups and influencing people (Hopson and Scally, 1980, 1982, 1985, 1987; TACADE, 1986). The alternative vision of what health education is for and what it looks like in the curriculum that was gaining

ground in this period can be linked to an **educational model of health education approach** (Tones, 1987). The model differs from the previously discussed preventive one in respect of the broad view of health that underpins it. It also differs in its goal, which relates to the encouragement of (support for) informed decisions on matters of personal behaviour relating to health.

In practice there is a tradition in which both the preventive and educational models of approach to health education co-exist within the education system (Tones and Tilford, 2001). This tradition would seem particularly evident in the case of health education on drugs. During the 1970s many schools continued to rely on ‘one-offs’, using outside speakers and films that did not relate to other parts of the curriculum and which adopted a prescriptive approach. Even in schools attempting the integrated, ‘low key’ approach, there was a tendency for them to become reliant on messages that played to fear and anxiety (ISDD, 1984). This tendency extended into the 1980s – a decade characterised by increasing availability of heroin and a hardening of drug control policy at national level. The new policy direction was based on a war-against-drugs model of approach. This model received comprehensive critique at the time (see Dorn and South, 1987 for a collection of alternative views about how the problem of heroin should be tackled) and leading commentators continue to implicate it in the policy failure to manage social drug use effectively (Parker et al, 1998). [Part of this approach involves the conceptualisation of schools as a frontline in the battle – a conceptualisation which, judging from recent Government pronouncements about a ‘new tough stance on drugs and schools’ continues

to influence official thinking (Education Minister Ivan Lewis cited in Cohen, 2002). The iteration of a new strong 'line' needs to be seen in the context of a successful impetus to get cannabis reclassified as Class C substance under the Misuse of Drugs Act. The Minister's high profile remarks were made on the eve of a cross party call for this change (Home Affairs Select Committee, 2002) and are part of a longstanding trend, on Government's part, to be seen to be 'tough' on drugs. Cohen's concern is that such rhetoric might create a climate favourable to the return of discredited shock horror tactics back on the agenda in schools].

For school-based drug education the political developments of the time had an unwelcome impact. Schools came under pressure to support media-based attempts to deter young people from drug use. Consequently, the topic-focused approach, which throughout the late 1960s and early 1970s lost ground to a broader idea of curriculum integration in health and social education, started to move 'back in the ascendancy' (Dorn and South, 1985: 208). On a more positive note the 1980s saw an expansion of school-based drug education. It also saw the introduction of some new approaches - some of them based on a radical new philosophy that took harm minimisation, as opposed to primary prevention, as its main focus (Cohen, 1992). Others were based on the presupposition that resistance training can address the cognitive and skill-related deficits of young people weak in relation to external social pressures (Botvin, 1983; Botvin and Dusenbury, 1989).

The most significant influence on the expansion of drug education provision in the latter half of the 1980s was the Education Support Grant for action to combat drug misuse. Lewis describes how, within a matter of months of the scheme being introduced in 1986, virtually every LEA in England and Wales had appointed a person to 'stimulate and co-ordinate action within the education service and other agencies' (DES, 1986 cited in Lewis, 1993). Stears, Clift and Blackman (1995) also place great emphasis on the initiative in the context of a wider argument about the 'rocky path' that health education has had to traverse towards general acceptance as a worthwhile educational activity. In their view, drug education in England and Wales had followed a typical British pattern of voluntarism and the schema addressed the lack of central direction which had resulted in 'drug education being (dis) organised at national, regional and school level' (Stears, Clift and Blackman, 1995: 177). In 1990/91 the drug support grant was changed to cover wider aspects of preventative health education, largely as a result of the spread of HIV/ AIDS. This development connects with a subsequent focus for discussion in this chapter: the decline and dilution of school-based drug/health education in the wake of the introduction of the National Curriculum. However, before moving on, it is important to pick up on the theme of the introduction of new approaches to drug education.

A key stimulus for innovation in relation to drug education approach was research-based evidence that none of the types of drug education so far developed (scare, factual or affective) had a good track record in reducing the rate of experimentation with drugs. This highlights the importance of evaluation in the drug education context and directs attention

toward Dorn and Murji's (1992) classic review of over 250 English language studies relating to effectiveness in drug education published in the 1970s and 1980s. The phenomenon of a 'halo effect' - each new wave of prevention tending to attract rather positive evaluations in its early years with more balanced evaluations taking some time to be published – deterred the authors from structuring their review under the headings of 'effective' versus 'ineffective'. Instead, they took conceptual approaches in the order in which they historically emerged and critically appraised the evidence on outcomes in respect to the criterion of reduction in use (demand reduction). This involved a focus on five different types of prevention programme - only the first three of which are directly applicable in the context of curriculum-based approaches to drug prevention:

1. *Information* for individual decision-makers (e.g. fear-making 'inoculations' and factual information for rational decision-making conveyed by education, local campaigns or mass media).
2. *Values and skills* for individuals assumed to have moral and social deficits (clearer moral values and better social skills for decision-making)
3. *Resistance training* for individuals weak in relation to external pressures ('say no' skills to resist pressure, and sharpening social norms against drugs)
4. *Community-based participation* for groups and communities under pressure (casual alternatives, broader community initiatives, black and other minority action)
5. Demand reduction *through low-level enforcement* (user accountability and enforcement incentives to enter treatment; targeting the purchaser; disrupting sites of retail sale)

In the case of some approaches (information programmes relying on techniques of fear arousal and values and general skills approaches employed in isolation) the reviewers found no grounds to conclude that they were effective in delaying first onset of drug use. In others (programmes combining factual information with an emphasis on the development of lifeskills) they concluded that the evidence showed promise.

The work of Dorn and Murji (1992) was an important influence on the mid 90s development of a consensus of ideas about the basis of good practice in drug education in school (Ives and Clements, 1996). The focus of discussion now turns from ideas to changes in the framework for drug education delivery and the way that these heralded in a new phase in the evolution of school-based drug education.

1.2 The framework for health education in schools (mid to late 90s)

The framework surrounding the delivery of programmes of drug education in schools at the time when the field work for this study took place was shaped by two policy initiatives that will be briefly considered. The first was the *Healthy Schools* project launched in Europe by the World Health Organisation (WHO, 1993). Although this initiative had a relatively minor impact within the education system as a whole, prior to the introduction of the Healthy School Standard at the very end of the decade (DfES, 1999), its ideals were seized on enthusiastically by certain Local Education Authorities in England. The area focussed on in the empirical study was an early pioneer of a local Healthy School Award scheme (Leicestershire Health Education Centre, 1996). Indeed one of the schools selected

as a case for in-depth research had received 'healthy school' status in 1994. The second initiative of relevance involved policy action to strengthen school-based drug education as a way of supporting the delivery of goals linked to the Major Government's wider anti-drugs strategy (Cm 2846,1995).

The Healthy Schools initiative

The WHO's Healthy Schools initiative was based on the concept of a health promoting school which:

aims at achieving healthy lifestyles for the total school population by developing supportive environments conducive to the promotion of health. It offers opportunities for, and requires commitments to, the provision of a safe and health-enhancing social and physical environment

World Health Organisation, 1993:

This concept built on the long established and widely accepted view that schools can promote the health and welfare of young people and is part of the wider emphasis placed on health promotion 'settings' within the new public health movement (Tones, 1996).

The approach that the European Office of the WHO adopted to get the whole school approach into wider practice was the establishment of a European Network of Health Promoting Schools involving forty countries. In keeping with the hopes and intentions of the initiative the way the project developed varied from country to country according to

circumstance. In the UK the key change introduced into the education system as a result of the initiative was the introduction of healthy school award schemes in areas where the LEA

Figure 1.1 WHO criteria for a health-promoting school

1. Active promotion of the self esteem of all pupils by demonstrating that everyone can make a contribution to the life of the school
2. Development of good relations between staff and pupils and among pupils in the daily life of the school
3. Clarification for staff and pupils of the social aims of the school
4. Provision of stimulating challenges for all pupils through a wide range of activities
5. Use of every opportunity to improve the physical environment of the school
6. Development of good links between school, home and community
7. Development of good links among associated primary and secondary schools to plan a coherent health education curriculum
8. Active promotion of the health and well being of school and staff
9. Consideration of the role of staff as exemplars in health-related issues
10. Consideration of the complementary role of school meals (if provided to the health education curriculum)
11. Realization of the potential of specialist services in the community for advice and support in health education
12. Development of the education potential of school health services beyond routine screening and toward active support for the curriculum

Source: Naidoo and Wells, 2000: 288

was committed to the holistic philosophy behind it. These schemes were devised to encourage schools to introduce and embed the incremental changes in ethos, curriculum, environment and relationships in conformity with the WHO criteria for a healthy school (WHO, 1993 – see Figure 1.1 above) and relied on interested institutions opting in.

The National Healthy Schools Standard was introduced by the Department for Education and Skills (DfES) in late 1999 and built on the success of pilot schemes in different parts of country. One of its constituent features, a programme of professional development for teaching and health professionals involved in the delivery of drug education, is relevant for the conclusions that arise out of the empirical findings and receives some discussion in the context of Chapter 8.

The initiative to strengthen drug education in schools

Background

Prior to discussing the guidelines, demands and expectations that framed the delivery of school-based drug education in the period when the fieldwork took place, it is useful to consider the background to the new policy approach announced in the *Tackling Drugs Together* strategy (Cm 2846, 1995). The most obvious source of influence on the model adopted by the Government was a report by the prevention working group of the Advisory Council for the Misuse of Drugs (ACMD, 1993) which advocated a national impetus to

strengthen school based drug education. Three important considerations lay behind the argument put forward.

The first consideration was evidence of a 'worsening drug situation' (ACMD, 1993: 4). This evidence took the form of data from routinely collected statistics on drug use/misuse supplemented by findings from local and national surveys of the health-related behaviour of young people and took as its reference point for comparison, data on prevalence presented in a previous (1984) ACMD report. According to the authors:

The relatively high levels of exposure to drugs, and of first time or experimental misuse of drugs, as opposed to frequent misuse of drugs, underlines the importance of dissuading pupils from experimenting in the first place, and persuading those who have experimented not to continue.

ACMD, 1993: 10

Programmes of curriculum-based drug education were described as 'an important weapon' in tackling the problem of the large numbers of people who pass through the education system 'to go on to experience drug misuse problems'. A rhetorical device that reinforces previously made points about the tendency for school-based health education to get harnessed to the state's wider interests in winning 'the war' against drugs.

The second consideration related to the impact of the 1988 Education Reform Act on the provision of school-based drug education. At the time when the working group met many commentators were of the view

'that the constraints and pressures associated with changes in the educational system since the introduction of the National Curriculum have served to undermine

the considerable gains that have been made in establishing a holistic model of health education in schools

Stears, Clift and Blackman, 1995: 168

The report stops short of acknowledging that school-based health education had come to be in a state of poor 'health' (Cale, 1997). It does, however, suggest that Government intervention to 'ensure that drug education receives the attention it deserves' is vital at a time 'when the education system itself is evolving and undergoing major changes' (ACMD, 1993: 18).

The third consideration involved some renewed 'grounds for optimism' concerning the ability of preventative drug education to influence attitudes and behaviour (ACDM, 1993: 16). The report is realistic about the limited influence that schools have over the climate of opinion on illegal and socially acceptable drugs and acknowledges the difficulties inherent in isolating the intervention from the outside world and measuring its effectiveness. At the same time it spotlights research that builds in encouraging fashion on Dorn and Murji's (1992) conclusions about the potential promise in life skills approaches/ programmes combining several approaches.

The Report's conclusions and recommendations went on to have a guiding influence over subsequent policy developments with relevance to drug education delivery in the school setting. The key conclusion concerned the need for a clearly articulated national strategy on school based drug education building on the National Curriculum and existing provisions to act as a framework for supporting local actions. The working group

articulated a set of principles to act as a basis for this strategy that are reproduced in Appendix 1 (and which subsequently went on feature as an appendix in the Department of Education's circular (DfE 4/95) on Drug Prevention and Schools). It was envisaged that the strategy would integrate activity at three levels and this is reflected in the report's recommendations most of which link to action required at national, LEA/ Regional and school level. The only recommendations which failed to have influence over the direction taken by Government, as set out in the relevant section of its Tackling Drugs Together strategy (Cm 2846, 1995), related to the training of teachers. The report argued that training to equip teachers for drug education delivery should be provided in initial teacher training programmes. It also highlighted the need for quality standards for the in-service training of drug educators and for action to enhance the prestige of the work and link it to career prospects. In these particular respects little progress was made for almost a decade.

The policy elements

As previously mentioned the policy backdrop to the framework for drug education provision at the time of the fieldwork was the Major government's three-year anti-drug strategy *Tackling Drugs Together: A Strategy for England* (Cm 2846, 1995). This, comparatively-speaking, 'enlightened' policy sought to address some of the flaws evident in earlier policy initiatives, for example by introducing new structures, local drug action teams (DATs), designed to improve co-ordination between relevant sectors and agencies on the ground (Baggott, 2000: 214). The following statement of purpose lay behind the strategy and highlights its emphasis on preventing drug misuse.

To take effective action by vigorous law enforcement, accessible treatment and a new emphasis on education and prevention to:

- increase the safety of communities from drug-related crime;
- reduce the acceptability and availability of drugs to young people; and
- reduce the health risks and other damage related to drug misuse

As part of its focus on young people the strategy placed emphasis on the need to ensure that schools

offer effective programmes of drug education, giving pupils the facts, warning them of the risks, and helping them to develop the skills and attitudes to resist drugs

Cm 2846, 1995

This was accompanied by an additional £5.9 million, to be made available to schools in 1995-96 under the Grants for Education and Support and Training programme, to train teachers and support innovative projects in drug education and drug prevention. In addition to this two other policy levers were introduced in to the system. The first was a requirement on schools to review their policies on drug education and managing drug-related incidents in the light of guidance from the Department of Education. The second was incorporation of the inspection of both these policies into the regime of the Office for Standards in Education (OFSTED).

The relevant guidelines were disseminated to the Head teachers of all LEA maintained and grant-maintained schools in circular 4/95 *Drug Prevention and Schools* (DfE, 1995a). Guidance for teachers on teaching about drugs within the National Curriculum (DfE/SCAA, 1995) and a digest listing teaching resources for schools (DfE, 1995b) were also

made available on request. The guidance highlighted the *minimum* requirements for drug education in schools as set out in the National Curriculum Science Order. (DfE, 1995c).

To comply with this order schools must ensure that pupils are taught:

- at **Key Stage 1** (5-7 year olds) about the role of drugs as medicines;
- at **Key Stage 2** (7-11 year olds) that tobacco, alcohol and other drugs can have harmful effects;
- at **Key Stage 3** (11-14 year olds) that the abuse of alcohol, solvents, tobacco and other drugs affects health and that the body's natural defence may be enhanced by immunisation and medicines and how smoking affects lung structure and gas exchange; and
- at **Key Stage 4** (14-16 year olds) the effects of solvents, tobacco, alcohol and other drugs on body functions.

Beyond this the Department for Education offered schools 'principles' to guide practice but, ultimately, allowed freedom for schools to 'decide for themselves how best to organise drug education for their pupils' (DfE, 1995: 5). These principles were based on the tenets for good practice articulated in the ACMD (1993) report and reflected the existing consensus on what works best in school-based drug education. Certain ideas have evolved in the light of experience and, where relevant, these changed emphases are highlighted in the discussion that follows [see Appendix 2 for key principles of drug education as set out in *National Healthy School Standard – Drug Education* (DfES, 2004a)].

A key principle highlighted in Circular 4/95 is that *drug education is generally best provided as part of an integrated programme of health education spanning all four key stages*. The accompanying curriculum guidance for schools (DfE/ SCA, 1995) outlined four models, usable in combination, that schools could adopt in their efforts to embed this principle into practice. These four models were: permeating the whole curriculum; located in one or more designated National Curriculum subjects; as part of a Personal, Social and Health Education programme; and as a part of a pastoral or tutorial programme. Under New Labour the emphasis has been placed on PSHE as the most appropriate curriculum context for drug education. The National Curriculum was revised in 2002 and one of the key changes made was the introduction of a non-statutory framework for PSHE and citizenship at key stages 1 and 2 and a non-statutory framework for PSHE at key stages 3 and 4 have been introduced (DfEE, 2002). Linked with this there has been a new policy expectation that schools will use this framework to supplement the drug education that they provide for their pupils in programmes of study for science.

Another principle conveyed in Circular 4/95 is that in the light of the common issues and requirements for teaching approaches (for example in equipping pupils to be able to resist peer pressure) drug education should include teaching about all drugs, including illegal drugs, tobacco, alcohol and volatile substances. The caveat attached to this is that a clear distinction needs to be maintained between illegal and legal drugs. Similar thinking remains evident in New Labour's revised drugs guidance to schools (DfES, 2004b). This emphasises that issues related to specific drugs should not be considered in isolation and

urges schools to set realistic programme aims which are consistent with the moral and values framework of the school and with the laws of society.

Circular 4/95 discourages schools from adopting a didactic stance in relation to teaching on drugs. Instead it is held that the essential aim of programmes of drug education is to emphasise the benefits of a healthy lifestyle, and give young people the knowledge and skills to make informed and responsible choices now and later in life. The circular is silent on the issue of whether harm reduction is a legitimate aim of drug policies and programmes. The omission of teaching resources based on harm reduction principles from the digest of recommended materials for drug education teaching did, however, send a coded message that schools should concentrate on primary prevention (Cohen, 1996). New Labour policy documents retain the emphasis on 'healthy, informed' choices and are upfront about the acceptability of a harm-reduction focus in drug education programmes targeted at high-risk youth (DfEE, 1998; DfES, 2004b). On the issue of whether school-based programmes should assist those who are resistant to ending drug-using behaviour to adopt safer practices the same documents are non-forthcoming.

Other important principles relate to the need for: well co-ordinated programmes, characterised by sensitive teaching matched to the particular needs and concerns of pupils in the class and based on credible and consistent messages delivered through a mixture of direct teaching and the use of interactive approaches to learning. The broad consensus behind these principles continues to this day as shown by the high profile of these ideas in relevant New Labour documents (DfES, 2004a; 2004b). For the sake of discussion to

follow it is useful to especially spotlight the policy emphasis placed on using children's and young people's existing knowledge, experiences and perceptions of drug issues as a starting point.

Early progress in relation to policy goals

There are three sources of information pertinent to the assessment of progress in relation to drug education-related policy goals in the era heralded in by the introduction of the Major government's strategic anti-drugs plan (Cm 2846, 1995). The first of these is monitoring data from the Office of Her Majesty's Chief Inspector of Schools - OFSTED; the second is studies focussing on the implementation of drug education programmes at school. The third is research designed to throw light on whether school-based drug education is effective in meeting the expressed needs of pupils.

The first official report on Drug Education in Schools (OFSTED, 1997) drew on evidence from visits to, and inspections of, primary and secondary schools during the 1995-1996 academic year as well as on data from a questionnaire survey of approximately 1,500 schools. This established that an increase in the proportion of schools possessing a clear drug education policy had occurred since Circular 4/95. It also reported that the quality of teaching about drugs was 'good' in over 60% of lessons across all Key Stages. On a more negative note, it found that 'too many schools' failed to make an assessment of pupils' knowledge and understanding of drugs before planning and teaching the programme. Furthermore that monitoring and evaluation of drug education programmes was not generally 'taken seriously' and that drug education programmes tended to lack

‘coherence’, especially if they were provided outside of a PSHE context. New guidance to on drug prevention was subsequently circulated to schools by the (DfEE, 1998; SCODA, 1998a, 1998b) and, judging from a second official monitoring report (OFSTED, 2002) led to some improvements. The report noted a significant increase in the number of schools with a drug education policy that has clearly stated aims and objectives and a programme of study designed to meet the needs of pupils. Balancing this it found that only a third of lessons at Key Stage 4 could be classified as good, that provision remains variable and that not all pupils are receiving drug education in line with Government guidance (OFSTED, 2002).

Findings from an implementation-focussed study carried out in three London boroughs (O’Connor et al, 1998) are very useful in light of the positive interpretation that has been put on ‘the improvement in the quality of drug, alcohol and tobacco education offered in schools’ within Government circles (Hellawell, 2001). This assessment draws heavily on OFSTED evidence relating to encouraging levels of policy possession at school level. Judging from the conclusions of this independent study, having a policy that conforms to quality standards on paper is no guarantee that practice at the chalk face will be recognisably ‘good’. On the basis of interview evidence from a sample of drug education providers supplemented with questionnaire data the authors concluded that conditions were unfavourable to the translation of

well intentioned statements of intent into ‘practical, effective working documents which inform school practice on a day-to-day basis’.

O’Connor et al, 1998: 71

The authors of this study called for action at national level (government), local level (Drug Action Teams and school level (senior management including governing bodies) to provide the 'managerial conditions' in which 'effective drugs policies can flourish'. Awaited findings from a qualitative study investigating the extent to which drug education in secondary schools in the North East of Scotland match effectiveness criteria will provide further indications about the extent to which policy development to strengthen the delivery of drug education in schools is working. At the time of writing the researchers have only published on the background and methodological aspects of their study (Fitzgerald, Stewart and Mackie, 2002).

As the receivers of programmes of drug education it is logical to turn to pupils for evidence to throw light on whether the provision of drug education is 'good'. Judging from the first evidence considered this adjective might not be totally appropriate. A mixed methodology study carried out in Surrey by Roker and Coleman, (1997) found that the majority of the 15-16 years olds in the sample had not had (or could not remember having) drug education in the last year. Compounding the issue of a level of provision below what the young people would have liked, the research participants did not rate the credibility of the teachers providing them with lessons very highly. They were also of the opinion that their drug education should have started at an earlier age. A more recent piece of qualitative research echoes endorses an important conclusion of Roker and Coleman's study via its finding that children and young people *want* drug education and school-based opportunities to discuss any substance-linked worries they may have (Butcher, 2000). They still, however, suggest that there is no room for complacency on the issue of the 'match'

between what young people want in the way of school-based input on drugs and what they actually receive.

1.3 Conclusions

This chapter has briefly charted the development of school-based drug education from a fringe subject to the cornerstone of the government's efforts to protect young people from drug misuse. The roots of the subject in temperance education and moral instruction to prepare young people for socially accepted roles have been highlighted. There has also been an examination of the various waves of new approaches in drug education that characterised the 1970s and 1980s. It was argued that policy development in the years immediately preceding the period 1996-1998 was related to the emergence of a consensus around some fundamental principles of good practice in drug education. Furthermore the delivery framework for drug education has been examined and found to comprise a combination of statutory requirements and non-statutory expectations on schools.

Several interesting issues have emerged. These include the legacy of early reliance on warnings approaches and moral exhortation (particularly at times when there is a strong political need to be seen to be doing something to tackle the drug 'problem'). It has also become apparent that there is an absence of debate about the role (if any) of harm reduction approaches within the context of school-based programmes of drug education. Also crucial are questions about the feasibility of translating knowledge about what works best in education into practice at the chalk face, and the effectiveness of drug education in

responding to young people's needs. The kind of research that could respond to these issues is evaluative – but not in the narrow, outcome-focussed sense that is usual in the drug prevention or health education context. The chapter that follows explores theoretical issues relevant to the evaluation of health interventions and develops a conceptual framework focussed on the implementation of principles of good practice in drug education. To bring this chapter to a close it is sufficient to state that the present study is in agreement that

‘without a good theoretical and evidential basis for the content and processes employed by drug education interventions, effectiveness is unlikely to improve’
Coggans, 1998: 14

In particular, it endorses the view that better understanding of the underlying *processes* of drug education could enhance the value of the intervention. In 1992 the authors of a review into the effectiveness of drug prevention approaches, that remains a classic of the literature, had similar thoughts. Indeed, they explicitly recommended that

Government and other funding agencies should encourage process evaluations – the recording of the actual processes of programme planning, negotiation and implementation and reception – since it is in this area that the literature is most deficient and valuable experience is being lost

Dorn and Murji, 1992: 4

CHAPTER TWO

Theoretical Issues in the Evaluation of School Based Drug Education

The first part of this chapter draws on two ‘alternative’ evaluation perspectives in order to establish the wider conceptual and methodological parameters to the research presented in this thesis. This is followed by a review of relevant models and theoretical insights with a view to identifying concepts that might account for ‘successes’ and ‘failings’ in the implementation of effective drug education practice at the chalk face. In the final section these concepts are incorporated into a provisional schema which informs the research questions.

2.1 The overall evaluation approach

The basis for considering the interpretivist and realist evaluation perspectives as ‘alternative’ is that they react against - and stand in contrast to - a positivist evaluation paradigm. At the heart of this paradigm lies an outcome-focussed, medical model which has come under increasing scrutiny in recent years. Health promotion theorists have challenged the hegemony of this model on the grounds that characteristic interventions are dissimilar to clinical interventions and generate different demands for evidence on which to base decisions (Fraser, 1996; Macdonald, Veens and Tones, 1996; Nutbeam, 1996; Whitehead, 1995; Hepworth, 1997; Macdonald, 2000; Tilford, 2000). In official policy

circles there is also growing recognition that the medical model has valuable but *limited* applicability to the evaluation of the complex realities of social intervention to tackle social problems and requires complementing with other approaches (WHO, 1999, Cabinet Office, 2003, HM Treasury, 2003; Davies, 2004).

The defining feature of the positivist (or rational-technical) approach to evaluation is the application of principles associated with experimentation in the natural sciences to the evaluation of social interventions. Classically this process involves the following steps: the formulation of a hypothesis; the standardization of the intervention; control of intervening variables; the measurement of effect in terms of (one or a few) objectively verifiable measures and, lastly, the statistical manipulation of numerical data to establish 'proof' about cause and effect. Underpinning the approach, which finds its apotheosis in the randomized controlled study design, is a set of positivist assumptions about the social world that contrast markedly with those that inform the two evaluation perspectives which receive consideration in the next part of the chapter. The first of these is the interpretivist paradigm, an alternative to positivist-framed evaluation that first emerged in the 1970s as part of the broader, social science backlash against positivism. The second is the more recent - (Pawson and Tilley, 1997) - realist framework for evaluation research.

Interpretivist evaluation

The interpretivist evaluation paradigm is a broad church including such approaches as illuminative evaluation (Parlett and Hamilton, 1976), pluralist evaluation (Smith and

Cantley, 1985), fourth-generation evaluation (Guba and Lincoln, 1981, 1989), stakeholder evaluation (Thomas and Palfrey, 1996) and critical evaluation (Everitt and Hardiker, 1996). Located within it are two different schools of philosophical thought: constructivism and critical theory. Whilst evaluators from the two traditions are motivated by different values and principles, a number of key orientations are shared. Their focus is upon the *processes* associated with social intervention, as opposed to its outcomes; their methodological preference is for qualitative research designs focused upon the perceptions and experiences of human actors caught up in the intervention.

The interpretivist evaluation paradigm initially came into being as a result of the challenge to the positivist paradigm of evaluation by social scientists with a constructivist or subjectivist understanding of the world. Ontologically this school of thought assumes that realities are socially constructed and that 'truths' are local and specific: in effect dependent, in terms of their form and content, on the persons who hold them. This viewpoint contrasts sharply with that of the positivist paradigm that considers reality to be governed by universal laws. The epistemology of the interpretivist perspective holds that the researcher, and the object of that research, are interrelated within the enquiry process. It views the research findings as a creation of the inquiry itself. These ideas stand in contrast to the central tenets of positivist epistemology, namely subject - object dualism and value-free inquiry. The subjectivist methodology is hermeneutic and dialectic, and involves the process of iteration, analysis, critique, reiteration, re-analysis and synthesis. In this, it

departs dramatically from positivist methodology that emphasises hypothesis testing and context-free variables (Labonte and Robertson, 1996).

In recent years subjectivists have been joined in their challenge of experimentally framed 'rational technical' evaluation by critical social scientists whose understanding of social reality is shaped by theories of power. The critique of positivist evaluation that is propounded by critical theorists has a great deal of common ground with the critique developed by subjectivists. Both critiques are based on a rejection of the ontological and epistemological assumptions that underpin the positivist paradigm and both have a fundamental dispute with the claim that scientific methods produce objective and value-free evidence about intervention effectiveness. The vision of evaluation that critical theorists put forward in the place of the positivist paradigm, however, differs markedly from the one proposed by subjectivist evaluators. Indeed, in its own right, it offers a challenge to the underpinning assumptions of subjectivism.

Critical theorists share the subjectivists' view that the social world is fundamentally different from the physical and natural one in that it is made up of people with subjectivities. Where they differ is in their belief that subjectivity is shaped and maintained by structural and interpersonal expressions of power that render some individuals and groups more powerful than others. This leads evaluators who work within this paradigm to reject the subjectivist evaluation methodology of privileging subjective experience and interpretation on the grounds that it fails to challenge, and may even support, the continued

existence of oppression and social injustice. In its place, critical theorists propose a methodological approach underpinned by an awareness of the unequal distribution of power within society and committed to provoking change in the direction of equality (Everitt and Hardiker, 1996).

Just as the philosophical and methodological assumptions of positivism lead to value being placed on quantitative approaches to data collection and data analysis, so the philosophical and methodological assumptions of both subjectivism and critical theory lead to value being placed on *qualitative* research methods. Within the paradigm there is no equivalent to the 'gold standard' of the experimental research design and no rigid hierarchy of evidence to guide decisions about what represents good and poor qualitative research into health-related interventions.

In the health promotion context the interpretivist perspective is most strongly associated with the evaluation of community health development initiatives (Beattie, 1995; Hardiker, 1995). Following the Ottawa Charter (WHO, 1986) which placed strong emphasis on the goal of community empowerment, such approaches have become an integral part of the health promotion repertoire of approaches. The approach has two key characteristics. The first is that interventions look to the community, as opposed to the individual, as the focus for development and change. The second is that interventions proceed in a 'bottom up', negotiated way in stark contrast to the more usual 'top-down', expert-led approach. On political grounds practitioners and researchers involved in community development work

have tended to be skeptical about the uses to which evidence about outcomes will be put by managers and planners. As a result they have been interested in developing alternative approaches that are more responsive to the needs and interests of less powerful groups. On ideological grounds they have tended to be drawn to qualitative methods which reflect 'democratic' values and respect for the autonomy and subjectivity of research participants.

A rare example of a study based on an interpretivist understanding of the appropriate conduct for evaluation, but focussed on a 'top-down' health promotion initiative, provides inspiration for how an evaluation of the implementation of good practice in school-based drug education could be framed. The study was undertaken by a team of researchers commissioned to evaluate a Health Education Council funded regional alcohol educational project in the South West of England. The research team explored stakeholder accounts of the nature of progress and blockages experienced by the professional development component of this project. This work generated rich insight into the way that the varied experience of the programme was mediated by general attitudes to alcohol education, organizational self-interest and broader organizational pressures. This insight had a practical application – the provision of advice to the HEC about the strategic and tactical issues – and supported and extended pre-existing analyses about the implementation challenges associated with programmes reliant on joint working across sectors (Harrison and Means, 1986; Means and Smith, 1988).

The next perspective that will be considered provides a complementary influence to thinking about the overall approach that the study on drug education in the school setting should take. The key drawback of interpretivist-framed evaluation studies is that their findings tend to have limited applicability beyond the immediate confines of the research scenario. In consequence their contribution to a body of knowledge that could be drawn on for the purposes of programme development is rather minor. Realist evaluation, on the other hand, gets around this problem by ensuring that ‘stakeholders’ fragmentary expertise is marshaled by the researcher’(Pawson and Tilley, 1997: 220) in such a way that it contributes to the general sum of knowledge about a given programmes (or families of programmes).

Realist evaluation

The realist evaluation paradigm, the architects of which are Pawson and Tilley (1997), is most closely associated with the evaluation of interventions in the field of social justice (see, for example, Tilley, 1993a and 1993b). The approach, which aims to address the limitations of both the positivist and constructivist approaches to evaluation, is orientated towards a scientific, but not experimental, methodological approach and rests on a set of more general realist assumptions about social reality and social research. The realist starting point is the belief that the social world is constituted by multiple ontological domains: domains that possess their own distinct properties and characteristics but which link together and interconnect on the basis of subtle and complex social processes (Layder,

1990, 1997). This sophisticated view is reflected in Pawson and Tilley's (1997: 63) conception of social programmes as social systems comprised of 'interplays of individuals and institution, of agency and structure, and of micro and macro processes'. It is also reflected in the more general realist orientation towards a mixed methodology strategy which enable researchers and analysts to

tap into the subjective predispositions and intersubjectively generated meanings that form the everyday lifeworld of social agents while at the same time also allowing access to the objective social systemic aspects of society (reproduced social relations, positions, practices and discourses and forms of power)

Layder, 1998: 177

Interest in the tapping into generative forces below the surface of reality unites critical and realist evaluators. Where the two schools of thoughts differ is their views on the issue of whether evaluative research should have a scientific basis. Critical evaluators approach their work with a wish to influence policy and practice in ways that protect and promote the interests of the (relatively) powerless subjects of social programmes and this involves rejection of efforts to stay non-aligned with regards to claims to truth (Everitt and Hardiker, 1996). Realist evaluators, accept that a cardinal purpose of evaluations is to feed into improvements in policy and practice. In their view, however, the best way of doing this is to generate findings that can contribute to a genuinely cumulative body of social-scientific knowledge in respect to given types of programmes. It flows from this they see nothing fundamentally ill judged about a research approach which *strives* to achieve objectivity and value neutrality.

The formula for ‘realistic cumulation put forward by Pawson and Tilley (1997: 117) is based on a generative paradigm of causality. This looks on cause in terms of the transformative *potential* of phenomena and concentrates on the liabilities and powers of subjects. Such a framework, it is argued,

Enables us to shake off those conceptual habits which allow us to speak of a program producing outcomes and to replace them with an imagery which sees the program producing chances which may (or may not) be triggered into action via the subject’s capacity to make choices.

Pawson and Tilley (1997: 38)

The logical development from this analysis is that evaluators are urged to ‘orientate their thinking to ‘context-mechanism-outcome configurations’ (Pawson and Tilley, 1997: 217) and to take the explanation of socially significant regularities (patterns) as their key evaluation goal. It is possible to put this more simply and powerfully: realist evaluation is about asking what it is about an intervention that works for whom in what context?

Questions about what it is about school-based programmes of drug education that lead to desired outcomes in certain groups of pupils (but not others) have not been central to the evaluations of school-based drug education that form the evidence base for intervention in this area (see Chapter 1). In the belief that such insight could make a highly useful contribution to the future development of policy and practice the current study will set out to explore the background to both the ‘successes’ and ‘failings’ of drug education in the school setting.

Summary

The broad conceptual and methodological parameters for the empirical study reflect the influence of evaluation perspectives that stand as alternatives to the medically influenced, rational-technical approach. The main purpose of the study is to provide a theorized account of factors helping and hindering the translation of drug education 'ideals' into action at the chalk face. To accomplish this the focus of research attention will be on:

- The nature and impacts of the processes underlying drug education in the school setting
- Subjective and objective (contextual) influences on the actions of stakeholders involved in programme planning, negotiation and implementation
- Subjective and objective (contextual) influences on the reactions of the pupils in receipt of drug education programmes

To ensure that influences operating at different levels of social organisation can be properly investigated a mixed methodology research design incorporating a range of data collection techniques will be employed.

2.2 The conceptual and analytical framework

The intention of this section is to review existing concepts, models and analytical frameworks relevant to the substantive topic of the research with a view to developing a conceptual schema that will guide the research and act as a basis for subsequent theoretical

elaboration. This approach is inspired by adaptive theory, a strategy devised by Layder (1998) as a practical way of supporting the realist ideal of the cumulation of social scientific knowledge. This approach encourages researchers to trade on the synergy that is created when elements of prior theory and empirical data are brought together. Its emphasis is placed on the ties between agency and structure in social life and the connection between macro and micro levels of analysis. It is thus judged very compatible with this study's analytical focus on the range of factors and processes underlying the delivery and reception of drug education in schools.

Perspectives for understanding policy delivery

Theoretical frameworks and models for analyzing how policy is put into practice provided the theoretical stimulus for the part of the schema concerned with the processes of programme planning, negotiation and implementation. Reviews of literature in this area agree that there are two main paradigms, of which the most established is the top-down, rational system approach (Parsons, 1995; Howlett and Ramesh, 1995). In this paradigm emphasis is placed on the policy goals identified by decision-makers at the top of the organizational pyramid. Consequently, researchers tend to focus their attention on the extent to which the conditions that would permit effective achievement of policy goals - are present within the system. In the contrasting, 'bottom-up' paradigm no sharp distinction is drawn between the decision-making and the implementation phases of the policy process. Instead implementation is seen to involve 'policy making' from those who are involved in putting 'it' into effect, and researchers focus their attention on the factors

and processes lying behind the choices of key policy actors at local level. Both of these perspectives contain suggestions and arguments with potential applicability to the delivery-focussed part of the conceptual schema that is under development. In the remainder of the discussion elements to be incorporated in the schema are italicized and given a bold type face for emphasis

Top-down frameworks of the implementation process

Before considering the classic ‘lessons’ yielded by top-down framed implementation studies it is necessary to point out two linked developments that have occurred in the academic field of policy analysis since the mid 70s. The first is a growing consensus that the ‘top-down’ model is based upon a set of flawed assumptions about the rational nature of the policy process (Hill, 1998). The second is a swing away from a conception of implementation as an administrative phase that follows on in logical sequence from policy-making towards a vision which sees implementation in terms of an evolutionary learning process (Majone and Wildavsky, 1978; Browne and Wildavsky, 1984; Browne and Wildavsky, 1987). Despite these developments, the top-down approach remains ‘stubbornly popular’ - indeed there are commentators who argue that it remains the ‘orthodox’ way of framing the study of policy delivery (Pollitt, 1996). The value of the top-down approach, in the context of the current effort to conceptualize the delivery of school-based programmes, is that it draws attention to some classic factors implicated in the phenomenon of the implementation gap. Given that research reviewed at the end of Chapter 1 suggests a discrepancy between policy ideals and actual drug education practice

at school-level, theoretical insight into likely contributors to this state of affairs is liable to be useful.

The main catalyst for the development of the 'top-down' model of implementation was the 'failure' of the social welfare initiatives spearheaded by President Johnson's administration in the USA in the mid sixties. Prior to this, there had been an assumption that once a policy decision had been taken its execution was a straightforward affair that did not merit a great deal of attention. This was now replaced by the realization that carrying out a policy is frequently every bit as complex and difficult as working it out and agreeing it. In the 1970's several models identifying factors making for successful implementation were proposed (Pressman and Wildavsky, 1973; Van Meter and Van Horn, 1975; Hood, 1976; Sabatier and Maziman, 1979). In the view of these models, implementation took place on the basis of the communication of instructions down an organizational hierarchy in a series of logical steps. At each level of the organisation more detail and specificity would be added until, at 'street level' (the 'coal-face', the 'grassroots'), actions finally impacted on the organization's customers/ clients/ dependents. Alternative conceptualizations of the authority structure as a network, rather than a neat pyramid, have characterized the work of some 'top-down' policy analysts (Dunsire, 1978). But such a perspective has offered no fundamental challenge to the two rational assumptions basic to the model: first, that implementation is a process in which 'x follows y in a chain of a causation' (Parsons, 1995 p 467); and second, that what counts as success, in the public policy context, can be well defined and readily quantified.

The publication of Pressman and Wildvasky's (1973) work on federal programmes for unemployed inner-city residents of Oakland, California is widely recognized as the study that did most to reverse the long neglect of the politics of implementation. This showed that job creation programmes were not being carried out in the manner anticipated by policy makers and involved and led to the top-down framed insight that implementation requires a good top-down system of control and communications. Further studies convinced that two researchers that 'unfulfilled promises can lead to disillusionment' and led them to recommend that if the system does not provide conditions conducive to good implementation then it is best that decision-makers 'rein in promises to a more attainable level' (Pressman and Wildavsky, 1986: 6). The notion that it is possible to identify the conditions that support 'ideal' implementation was subsequently taken up and developed further by other policy analysts. First came an influential treatise on the 'limits to administration' (Hood, 1976). Next a seminal article addressing the question of 'why is implementation so difficult'. In this Gunn (1978) proposed a model of implementation that incorporated Hood's ideas about the importance of clear lines of authority, good channels of communication and lack of time pressure and extended them with insights of his own. The article also proposed ten conditions to provide a framework of issues that might be focussed on in relation to a given programme.

- Circumstances external to the implementing agency do not impose crippling constraints
- Adequate time and sufficient resources are made available to the programme.

- Not only are there no constraints in terms of overall resources, but also at each stage in the implementation process the required combination of resources is actually available.
- The policy to be implemented is based on a valid theory of cause and effect.
- The relationship between cause and effect is direct and there are few, if any, intervening links.
- There is a single implementation agency which need not depend upon other agencies for success.
- There is complete understanding of and agreement upon the objectives to be achieved and these conditions persist throughout the implementation process.
- In moving towards agreed objectives it is possible to specify, in complete detail and perfect sequence, the tasks to be performed by each participant.
- There is perfect communication among, and coordination of, the various agencies involved in the programme.
- Those in authority can demand and obtain perfect obedience.

The top-down approach to the study of implementation continues to be influential in the sphere of educational policy analysis. For example, research by Bolam (1975) and Fullan (1982) has suggested a number of conditions for 'success' in relation to the implementation of educational innovations. Researchers with a specific interest in the delivery of drug education in schools have drawn on this research. A recent study focussed on the implementation of drug education policies in three London boroughs (O'Connor et

al, 1998) implied that the established gap between intentions and day to day practice needed to be understood in the light of negative answers to the following questions:

- Does a clear understanding of the change process exist?
- Are the necessary skills and knowledge available to carry through the change?
- Are resources available to support the change, for example training and teaching materials, time for planning and reviewing?
- How committed are the implementers of the change process to the change itself?
- Is there clear direction from those who have initiated change?

On the assumption that top-down action to strengthen school-based drug education has the potential to assist the delivery of good practice at school level the *national delivery framework for school-based drug education* is identified as a necessary element of the conceptual schema under development through review of the literature. This framework is taken to comprise the statutory and non-statutory expectations on schools as set out in official guidance (DfE, 1995 a). It is also taken to include other support documents (DfE, 1995 b; DfEE/ SCAA 1995) as well as financial resources channeled into drug education via Local Education Authorities (see chapter 1).

Bottom-up frameworks of the policy process

The top-down model of implementation no longer commands the same levels of support that it did in the 1970s. A strong theme in the critique is that the model leads to a neglect of ‘downstream’ policy actors and organizational interactions and the significant role that they play in putting policy into effect. Amongst the first to mount this argument was

Lipsky (1971) who drew attention to the impact of the behaviour of ‘street-level’ bureaucrats on the success of the translation of policy goals into action. Also significant, in terms of the developing critique, were papers by Elmore (1978) and Hjern and colleagues (1978) who made a case for a new methodology for implementation studies based on a ‘bottom-up’ approach. The bottom-up framework is vulnerable to the criticism that it gives decision-makers no clear guide to the steps that they should take to ensure that their policies have the desired impact on their intended recipients. Its advantage in the present context is that it puts the agencies and actors with key responsibilities for policy implementation at local level under the spotlight and, in the process, highlights implementation-relevant factors which are liable to be overlooked if a top-down framework of policy analysis is relied on.

A particularly important landmark in the development of a ‘bottom-up’ approach to the analysis of implementation was the publication of *Street level bureaucrats and institutional innovation: implementing special education reform* by Wetherley and Lipsky (1977). This study found that that despite being implemented under conditions which would be classically regarded as auguring well for success, a Massachusetts law aimed at changing the practices of service providers did not have the positive effects on service providers that policy makers intended. On the contrary the extra bureaucratic workload that the law generated for public sector workers actually made matters worse – to the extent that services for clients with special educational needs were only maintained at existing levels

because of creative 'coping strategies' employed by dedicated and committed people at street-level.

In the wake of studies focussed on policy delivery at street-level (the grass-roots, the coal-face) new models of implementation based on a quite different set of assumptions than those that characterize the top-down models have emerged in the literature. The most prominent bottom-up approach in the policy analysis literature is the 'policy-action continuum' model developed by Barrett and Fudge (1981; 1984). The authors' starting point is that implementation can best be understood in terms of a policy action continuum in which an:

interactive and negotiative process is taking place over time, between those seeking to put policy into effect and those upon whom action depends

Barrett and Fudge, 1981: 25

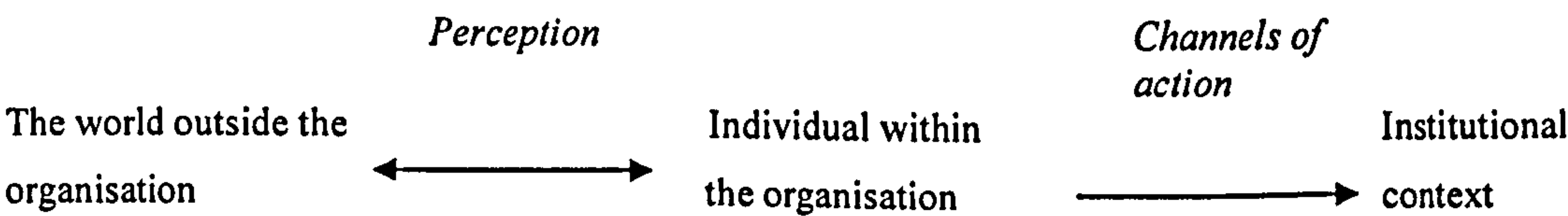
They then go on to argue that the political processes by which policy is mediated, negotiated and modified during its formulation and legitimization do not stop when initial policy decisions have been made. Instead they continue to influence policy through the behaviour of those responsible for its implementation and those affected by policy making 'to protect and enhance their own interests' (Barrett and Hill, 1984 p 220).

One of the key implications of this particular conceptualization of implementation is that emphasis is placed on the negotiation and bargaining behaviour (including the possession and use of 'bargaining counters') of the various groups of policy actors involved in a given policy within an organisation or system. This creates natural interest in the 'value systems, interests, relative autonomies and power bases' that lie behind these interactions (Barrett

and Hill, 1984 p 22). It also suggests that policy analysts have to attend to psychological phenomenon (for example ‘group-think’) and sociological issues (such as institutional culture) not usually included within the frame of their studies (Politt, 1996).

Another model that operates on the assumption that policy is something that ‘evolves’ or ‘unfolds’ over time was developed by Lewis and Flynn (1978; 1979) on the basis of research in the field of urban and rural planning policy. Depicted as a framework concerned with understanding implementation in terms of ‘getting things done’ the model captures a diverse range of factors affecting the implementation of policy. Like Barrett and Fudge’s model it is focussed on factors that affect the scope for action and behaviour of individuals and agencies. Unlike their model it draws explicit attention to the role of perception in the determination of policy-action at local-level (figure 2.1).

Figure 2.1 Lewis and Flynn’s model of implementation



Source: Lewis and Flynn (1979: 129).

The framework takes as its basic unit for analysis individuals and groups working within an organizational and institutional context and offers the central proposition that individuals have to attempt to match or fit the problems of the real world with the available channels of action. According to the model the problems and channels of action are relatively fixed and therefore offer considerable constraints on choices available: ('time, money and politics' are identified by Lewis and Flynn (1979 p 130) as the main constraints on the actions of individuals responsible for the implementation of public policies). At the same time they are not immutable; choices are possible and changes can be introduced. Policy actors' subjective perceptions of their options (scope for action) thus, provide Lewis and Flynn with one of their key foci for analysis.

These bottom-up models have two implications for the development of the schema that is in the process of assembly. First they suggest that the *negotiations behind programmes plans* (model of curriculum delivery, schedules, lesson plans etc) should be incorporated as a central element on the grounds that the realities of practice are shaped by compromise and bargaining between policy actors within institutional contexts. Second they suggest that *factors extrinsic to the organisation* and *factors intrinsic to the organisation* should both be incorporated as likely influences on the product of these negotiations. With regard to the former, bottom-up frameworks suggest that the level of *resources* within the educational system together with the environment of statutory *demands* and less formal *expectations* in relation to the role and responsibilities of schools are liable to be pertinent issues. With regard to the latter, the same frameworks indicate a need to incorporate a

focus on the *political priorities, power structure* and *culture* that characterize schools as units of social organization.

Perspectives for understanding the dynamics of drug-related communication

Conceptualization of the process whereby drug-related information and ideas are communicated to pupils draws on social-psychological theory in the field of persuasive communication. Before moving on to consider specific insights with relevance for this aspect of the reception dynamic it is necessary to briefly justify why this body of theory was chosen as a source of inspiration for the development of the schema. Drug education modeled on preventative lines (see discussion of philosophical models of health education approach in Chapter 1) clearly fits the definition of persuasive communication as

‘a conscious attempt by one individual to change the attitudes, beliefs or the behaviour of another individual or group of individuals through the transmission of some message.

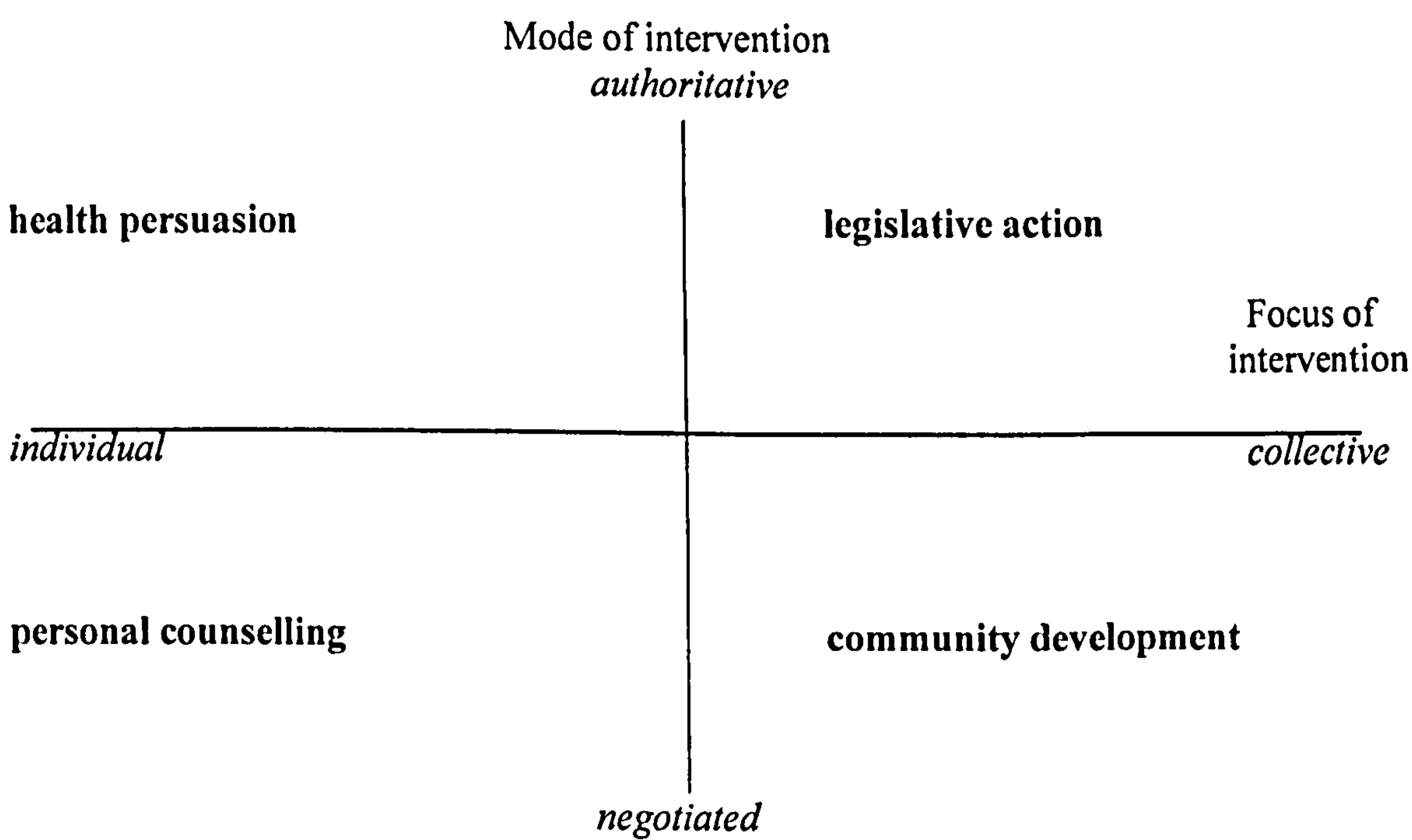
Bettinghaus, 1973 p 10

Drug education modeled on educational lines is less coercive but, nonetheless, places much reliance on the communication of information and ideas (about health risks and consequences, pertinent to the development of relevant skills that are geared to benignly *influence* the choice making of individuals in pre-determined, ‘healthy’ directions.

A well-established theoretical framework for differentiating between health promotion approaches developed by Beattie (1991) endorses the view that school-based programmes

of drug education, regardless of shade, employ persuasion as the means through which they attempt to exert benign influence over the substance-related choices of their subjects. This model uses two axes, mode of intervention and focus of intervention, to differentiate between four different paradigms of health promotion approach. The ideal ‘types’ that are generated using this approach to classification are health persuasion, legislative action, personal counseling and community development (Figure 2.2)

Figure 2.2 Beattie’s structural analysis of health promotion approaches



Source: Beattie, 1991: 229

On the grounds that they work on an *individual* (as opposed to collective) basis and respond to top-down diagnosis of need influenced by authoritative (expert) conceptions of 'healthy' choices school-based programmes of drug education agenda are placed firmly in the health persuasion quadrant.

Although there have been several decades worth of studies focussed upon the intervention strategy of persuasive communication, no theories or models allowing for the reliable prediction of the outcome of the process have emerged. This body of research has, however, yielded a degree of insight into communication-linked factors implicated in the success (or failure) of attempts to modify attitudes through persuasive means. In the first section of the ensuing discussion attention is focused on insights associated with discrete communication variables that have long interested researchers and theorists in the field of persuasive communication. In the second section attention is concentrated on a more recently proposed integrating framework that deepens understanding of the social psychology of persuasive communication. The limitations associated with this individualistic approach are freely acknowledged and will be addressed, later on in the chapter, through a review of sociological analyses that emphasize the importance of the cultural resources and social realities that condition young people's receptivity to health education arguments on drugs.

Early theories of mass communication

The material in this section is structured around consideration of three communication variables – the source, message and the receiver - that dominated the attention of researchers and theoreticians working within the communication research programme based at Yale University. This programme ran from the mid-1940s to the mid-1960s, and its findings provide the footing of current knowledge about what works best in persuasive communication. Subsequent discussion is focussed on insight with clear relevance to the communication scenario of school-based health education on drugs. Instead of relying on primary sources - (Hovland and Weiss, 1951; Hovland et al, 1953; Berlo, Lemert and Mertz, 1969/70) - use has been made of two existing reviews of research and theory in this field. The first is a Home Office paper designed to provide guidelines for practitioners using the media for drug prevention work (Hastings and Stead, 1999). The second is an academic overview of theory relevant to persuasion and attitude change in a recent health text (see chapter on *Education for health: the conditions for learning* (Tones and Green, 2004).

Source factors

Aristotle is the first known theorist to have formally acknowledged the source of communication as a key influence in persuasive communication contexts. In his writing on the subject of rhetoric he argued that ability to sway an audience depends on a speaker's 'good sense', 'good moral character' and 'goodwill'. Many hundreds of years on findings generated by the Yale research programme clarified that the important issue is not the

‘objective’ characteristics of the source but is how those on the receiving end of a communication perceive it (Bettinghaus, 1973).

Hastings and Stead (1999) highlight visibility, credibility, attractiveness and power as the four most important features identified by research. Visibility relates to the ease with which an audience can attribute a message to a source. Credibility is the degree to which a source is perceived to be expert, trustworthy, objective and believable. A source is attractive if there is felt to be some common ground between the source and the receiver and is most important if the aim is to stimulate audience identification and an emotional reaction. Power, or influence means that theoretically a source which is perceived to have power over an audience can influence them (at least in the short- term) to comply with a message.

Message factors

Tones and Green (2004) highlight a number of message-linked factors that have occupied researchers and theoreticians in the field of persuasion and led to insights with relevance for practice. Research to clarify the impact of repetition, primacy and recency has failed to support the common assumption that the more frequently a message is repeated the more effective it will be. By contrast, a great deal of experimental evidence has been accumulated to demonstrate that a message delivered first or last in a sequence of different persuasive attempts is more likely to be influential. Studies designed to ascertain the relative merits of implicit v. explicit conclusions in the construction of the message have

also yielded useful insights. In particular they have established that expert or intelligent audiences tend to demonstrate a greater shift in opinion and attitude with implicit conclusions whereas less experienced or intelligent people are more likely to be persuaded if they are told directly what they should believe. The key lesson to be drawn from studies to investigate the influence on message *sidedness* on the success of persuasive communications can be summarized as ‘horses for courses’. If the audience is well educated, intelligent, or both, a two-sided approach (both sides of an issue) have been shown to be more effective. If the audience is uneducated/unintelligent and/or it can be guaranteed that it will not be exposed to counter arguments, the one-sided approach tends to work best.

Tones and Green link the state of knowledge on message sidedness – in particular the finding that people exposed to two-sided messages who already favoured the advocated message maintained their support, even when exposed to attempts to change their commitment – to McGuire’s (1964) theory of social inoculation. This theory is somewhat analogous to the practice of inoculation against disease. In the medical scenario, exposure to weak doses of the biological agent in question stimulates the immune system and promotes resistance against future attack. In the health education scenario, belief resistance is promoted through exposure to attacking material strong enough to stimulate defenses but not strong enough to overwhelm ‘healthy’ beliefs and intentions. Latterly the analogy of immunization has been further extended to include the use of ‘booster’ doses of education to maintain immunity. A pioneer in the drug prevention field is Botvin (1984) who

increased the success rates of this 'lifeskills training model' by incorporating a booster element into the programme.

Tones and Green (2004) are ethically opposed to deliberate attempts to create negative affect, and cite review evidence that throws doubt on the effectiveness of techniques appealing to fear in the smoking prevention context (Leventhal and Cleary, 1980). Even-handedly, however, they acknowledge review-based evidence regarding the effectiveness of carefully designed and implemented persuasion strategies based on the technique of appeal in certain health education contexts (Hale and Dillard, 1995). The explanation that they proffer for the seeming contradictory research findings that characterize the literature in this area implicates the wide range of relevant, intervening variables (for example, the perceived ease or difficulty of the proposed action, the social class background, age and/or anxiety levels of the audience). Hastings and Stead (1999) concur that reactions to appeal to fear are very complex and point to findings that suggest proximity to the behaviour concerned is another important issue that needs taking into account (Ray and Wilkie, 1970). They go on to suggest that parents who have little knowledge or understanding of drugs would find shock tactic campaigns very effective, while drug users or those with knowledge of drug users would find it less so and caution that:

there is evidence both for and against the use of fear arousing messages in drug prevention, with serious cautions and qualifications offered even by those who suggest that they do have a role to play. The use of fear messages is extremely complex and the safest option, if they are to be used, is to do so with great caution and take particular care with pre-testing and targeting.

Hastings and Stead, 1999: 14

Audience factors

The contribution of the audience to the success of attempts to change attitudes through communicative means represented a popular focus for Yale researchers. Tones and Green (2004) present the established finding that individuals in the middle of the self-esteem distribution are the most susceptible to persuasion and account for this on the grounds that individuals with high self esteem are better able to defend their beliefs against attack. Individuals with low self-esteem, in contrast, are more likely to resort to defensive avoidance and denial. They also consider the audience characteristics of dissonance and reactance. Dissonance refers to a state of imbalance between personal beliefs, attitudes and behaviour and is thought to equate with the states of guilt and anxiety in terms of their capacity to influence intentions to act. Reactance refers to the psychological tendency for receivers to react negatively to messages they construe as part of an attempt to curtail their freedom of action.

Hastings and Stead (1999) place their emphasis on the implications of the many theories that have been developed to try and explain how media communication ‘works’ in terms of audience response. The lesson that they draw from this body of work is that

the audience bring preconceptions, experiences, knowledge, concerns and cultural beliefs to a message, and these may have major implications for how they interpret and react to it

Hastings and Stead, 1999: 11

In response to this they underscore the value of audience segmentation and targeting in the drug prevention context. Significantly, in the context of the current research, they point out

that different groups of young people are liable to have different information and communication needs and, as a result merit customized approaches. This argument is supported by research evidence that younger adolescents may respond better to information, particularly about the basic prevalence of drug use among their peers, and to interventions encouraging decision-making, while older adolescents may respond better to messages about safer use and alternatives (Austin, 1995). Arguments about the different attitudes and needs of non-users, experimenters and regular users (Bandy and President, 1983) and of adolescents at high and low risk of serious drug problems (Coggans and Watson, 1995) are also marshaled to support this key point.

The model reviewed in the next part of the discussion builds on early understandings about the need to refine the presentation of a message according to receiver's characteristics. Its key value in the context of the current effort to identify concepts pertinent to the delivery of drug education is that it suggests that the process of *interaction at the pupil-teacher interface* needs to lie at the heart of the schema.

Insights from the Elaboration Likelihood Model of persuasion

Since the sixties a trend towards increasingly sophisticated psychological accounts of how messages are received and responded to has been evident in the communication field. The Elaboration Likelihood Model of persuasion (ELM), developed by Petty and Cacioppo (1986), has been chosen for attention because it represents an attempt to integrate the

‘many seemingly conflicting research findings and theoretical orientations’ on source, message, recipient and context variables under ‘one conceptual umbrella’ (Petty and Cacioppo’s. 1986: 125). Elaboration, in the context of the ELM refers to the extent to which a person thinks about the issue-relevant arguments contained in a message. When conditions foster people’s motivation and ability to engage in such issue-relevant thinking the likelihood of them ‘centrally processing’ (or elaborating on) the message is said to be high. Such processing involves evaluation of arguments, assessment of conclusions and their integration within existing belief structures and any resulting attitude change is likely to be enduring and predictive of behaviour. In contrast, when individuals are unmotivated to receive an argument, have low issue involvement, or incongruent beliefs, ‘peripheral processing’ is seen as the most likely outcome. In this case attitude change (if it takes place) occurs not on the basis of careful and thoughtful consideration of the true merits of the information presented in the support of an advocacy. Instead it represents a response to some simple cue (e.g. an attractive source) in the persuasion context. These insights have important implications for practice as they suggest that messages that are congruent with social beliefs require very different packaging to those that present new or conflicting information. They also have implications for the analytical framework that this Chapter aims to develop. The ELM highlights the importance of the cognitive state of the recipients of school-based programmes of drug education and suggests that pupils’ *pre-dispositions to health education arguments* should be incorporated into the reception-focussed part of the schema.

Psychological perspectives pertinent to pupils' reception of drug education

Within health promotion psycho-dynamic frameworks, and in particular models of social cognition, represent the dominant paradigm for understanding youth and their risk-taking. A serious weakness of such models is that they fail to recognize the social and cultural context of beliefs and action and this thesis agrees with the analysis that there is a need for

sociological explanations that argue that risk-taking is more a result of how young people interact and negotiate with their social worlds, putting culture and context at the centre of these processes.

France, 2,000: 327

Sociological perspectives will receive consideration in due course in order to ensure that the conceptual framework in development incorporates relevant factors linked to the wider context that surrounds the reception of drug education programmes by young people. The rationale for reviewing social-psychological perspectives at this juncture is that subjective influences on pupils' receptivity to messages geared to the discouragement of substance-related risk taking are also deemed relevant to the schema. The discussion is not meant to be exhaustive [see Nutbeam and Harris (1999) for a comprehensive review of leading social-psychological frameworks drawn on to inform the planning of health promotion interventions aimed at influencing behaviour at the individual level]. Instead it provides some insight into the psychological basis of young people's personal dispositions to health education arguments.

Insight from models of social cognition

The great advantage of the social cognition models in the health promotion context is that they highlight beliefs and attitudes that could be potentially modified with a view to influencing health behaviour (Connor and Norman, 1996; Bennett and Murphy, 1997). The concepts of threat perception, outcome expectancy, perception of control and normative influence feature prominently in leading frameworks and are briefly considered below. In each case there is reference to theoretical insights that help to explain why young people in the adolescent phase of development may fail to react as hoped and expected to influence targeting the perception in question.

Threat perception

The notion of threat, as measured by perceived susceptibility and perceived severity, is a key dimension of the 'Health Belief Model', the oldest and the most widely used social cognition model in health psychology (Rosenstock, 1966; Becker, 1974). Despite empirical evidence suggesting that perceived susceptibility and perceived severity are not reliable predictors of health behaviour (Janz and Becker, 1984) the construct of threat perception has survived revisions of the Health Belief Model and subsequently been incorporated into other models of health behaviour. 'Protection Motivation Theory' (Rogers, 1983) is the most notable example.

Although school-based drug education programmes possess the *theoretical potential* to heighten recipients' subjective perception of the health threat represented by smoking, drinking and/or drug use, there is no guarantee that the arguments they contain about risk will be received or acted on as intended. Several decades of risk-research has established that a 'strong but unjustified sense of subjective immunity' is fairly universal; it has also shown that, in the case of adolescents, the tendency to operate with an exaggerated sense of invulnerability is particularly strong (Douglas, 1986 p 29). A popular explanation for this is the *personal fable* (Elkind, 1967; Jack, 1989). This has been described as:

a belief held by many adolescents telling them they are special and unique, so much so that none of life's difficulties or problems will affect them regardless of their behaviour

Jack, 1989: 334

In the view of Jeffrey (1989) this is compounded by a tendency for adolescents to disregard the implications of a nasty outcome from a risk on the grounds that the dangers relate to something that will not happen for a long time.

Outcome expectancies

Most of the social cognition models applied to health behaviour and health behaviour change incorporate an element of focus on the perceived consequences of performing a health-related action. In the 'Theory of Reasoned Action' (Fishbein and Ajzen, 1975; Ajzen and Fishbein, 1980), and its successor the 'Theory of Planned Behaviour' (Ajzen, 1988;1991), the focus is on behavioural beliefs. In the Health Belief Model it is on the costs and benefits of performing a given aspect of health behaviour. In 'Social Cognitive

Theory' (Bandura, 1977; 1986) it is on outcome expectancies and in Protection Motivation Theory it is on response efficacy.

Drug-related inputs in the formal and hidden curriculum have the potential to heighten pupils' perceptions about the negative consequences of substance use/ experimentation for health and social approval. A probability judgement about the likely 'costs' of a given behaviour is only part of the equation, however. Also relevant for outcome expectancies are probability judgements (or lay beliefs) relating to 'benefits'. It is argued that being a risk-taker can give young people social status, pleasure and personal gain (Plant and Plant, 1992). Qualitative research also suggests that that substance-related risk taking makes a positive contribution to young people's sense of self and identity (Lloyd and Lucas, 1998; Denscombe, 2001). This suggests that any positive effect that school-based intervention might have in relation to increasing pupils' appreciation of the costs of substance-related risk taking is vulnerable to the counter-effect of knowledge and arguments about substance-related benefits derived from learning experiences beyond the school-gates

Perceptions of control

Since Ajzen (1988) introduced the construct of perceived behavioural control into the Theory of Planned Behaviour considerable attention has been focused on this particular cognitive variable. Unlike the earlier 'locus of control construct' (Rotter, 1966) which was a generalized expectancy, seen to be relatively stable across different situations, perceived behavioural control is behaviour-specific and liable to vary from one situation to another.

The construct relates very closely to the construct of ‘self-efficacy’ as embedded in Social Cognitive Theory. However, whereas self-efficacy emphasizes an individual’s confidence in relation to the performance of a given health action, perceived behavioural control places more emphasis on an individual’s perceptions regarding the ease or difficulty of its implementation. The Health Belief Model also incorporates a control-related dimension, in the form of a perceived barrier construct that incorporates beliefs about internal and also external barriers to a given healthy behaviour.

Through the taught and hidden curriculum schools have the potential to boost young people’s sense of being in control with regard to the implementation of healthy choices. In the case of what goes on in lessons the efficacy of interaction geared to development of relevant capacities and skills is put in doubt due to an emphasis on the transmission of strategies for saying ‘no’ to peer pressure. Many researchers have challenged the assumption that young people are *pressurized* into substance use by their peers (Friedman et al, 1985; Eiser et al, 1991; Coggans and McKellar, 1994; Engels et al, 1997; Frankham, 1998). The implication to draw is that an erroneous internal barrier to ‘healthy’ drug-related choices is being targeted. ‘Messages’ in the hidden curriculum arguably have more potential to make a health promoting difference through the successful targeting of external barriers to healthy choices. Realistically, however, the wide availability of drugs for adolescent pupils (Balding, 1995) has great power to undermine schools attempts to place restrictions on smoking and operate a zero-tolerance line to drugs on school premises.

Normative influences

In the Theory of Planned Behaviour subjective norms (and their determinants, normative beliefs) are proposed as a key predictor of behavioural intentions (Ajzen, 1991). Subjective norms are held to consist of a person's beliefs about whether significant others think he or she should engage in the behaviour. Significant others are individuals whose preferences about a person's behaviour in this domain are important to him or her. Other models of social cognition fail to explicitly cover the normative influences on behaviour and, in the analysis of Connor and Norman, (1996) the failure to take into account the social pressures that individuals feel under to perform or not perform a particular behaviour detracts from their predictive capabilities. In fairness, in the Health Belief Model normative influence is listed as one of many potential cues to action. Social Cognition Theory (Bandura, 1986) also caters for perceptions in this area via its construct of outcome expectancies.

Drug education programmes have the potential to support the avoidance of substance-related risk taking as a norm. 'Success' in this area, however, is compromised by macro-level developments. On the basis of findings from mixed-methodology, longitudinal research in the North West of England a thesis about the developing 'normalization' of recreational drug use in the leisure contexts of youth has been proposed (Parker, Aldridge and Measham (1998). The explanation the authors give for this development draws on wider theorizing about the nature of modernity (Giddens, 1991, Beck, 1992). The immediate implications for school-based drug education is that a large number of

adolescents are likely to pass through a phase of ‘normative’ experimental and recreational drug use that will inevitable have a negative impact on their receptivity to messages geared to the eradication of risk.

The Health Action Model

To address some important ‘blindspots’ in social cognition models of health behaviour Tones (1987) has developed a comprehensive framework which he entitles the Health Action Model. This model incorporates the various perceptions that have already been discussed. It then supplements them with other factors, both cognitive and non-cognitive, which population studies have shown to be linked to personal health behaviour.

A key feature of the Health Action Model (Figure 2.3) below is its identification of three major systems that interact to determine health behaviour. The Belief System and the Normative System are based on cognitive constructs that have already been discussed. The motivation system, in contrast, describes a complex of affective elements that are held to ultimately determine the individual’s attitude to the specific action and his or her intention of adopting it. This addition addresses one of the key criticisms leveled at models of social cognition – namely their underlying supposition that health-related choices are the product of purely rational thought processes as part of this complex is the (emotionally charged) values that an individual holds as a result of their socialization experiences. These may be

all embracing in nature, as in the case of religious or moral values, or may involve feelings in relation to specific issues such as family or work. Another part of this complex is an individual's attitudes including, crucially, their attitudes towards themselves (self-esteem). Emotional states and drives (for example linked to addiction) are the two remaining feelings-related components that make up the motivational system.

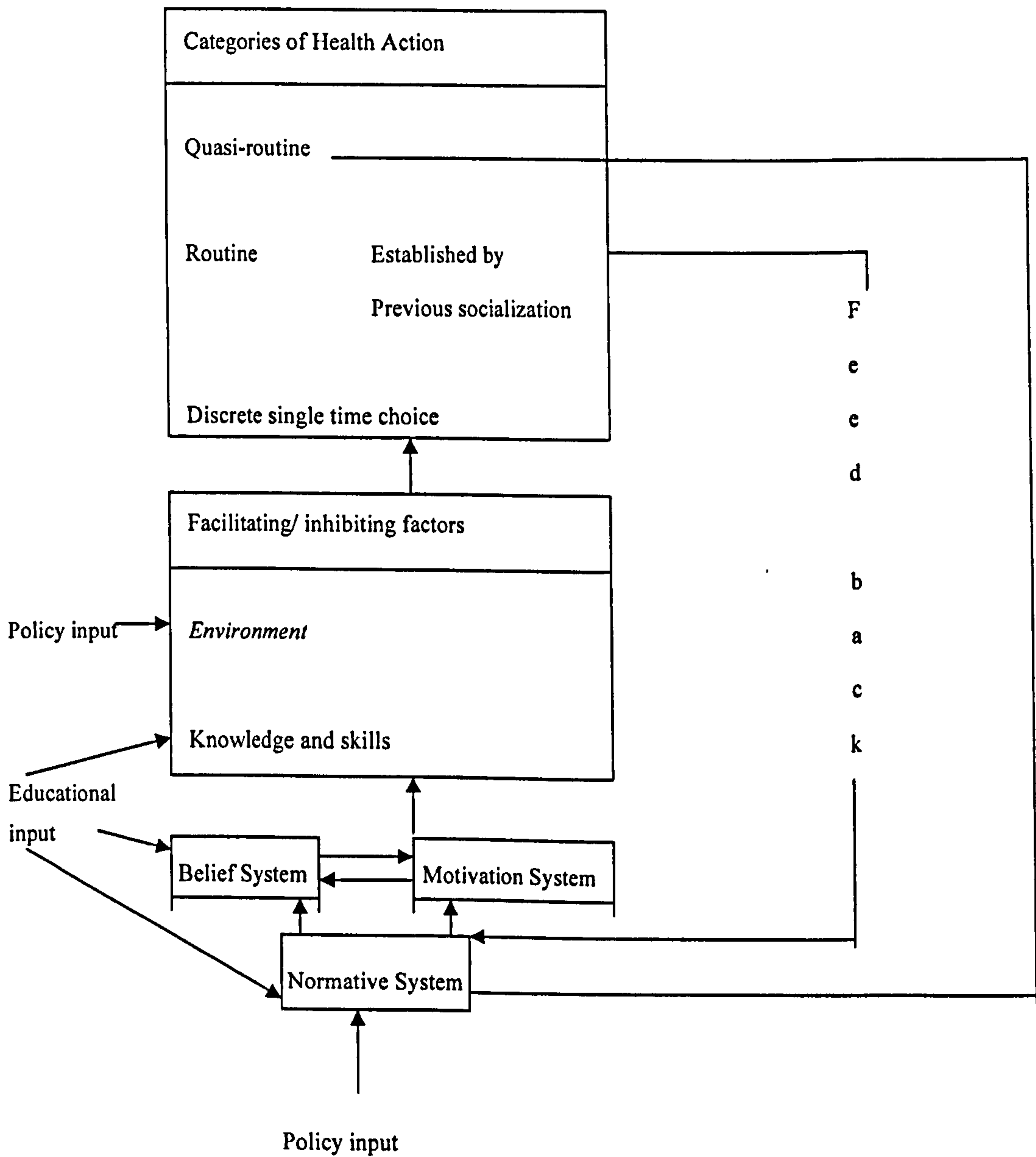


Figure 2.3 The health action model: an overview (*Tones and Tilford, 2001: 52*)

In addition to its three key elements, the belief system, the normative system and the motivational system, the model incorporates other variables that are significant in the health action context. It draws a distinction between routine, quasi-routine and discrete single-choice categories of health action – distinctions that are glossed over in the models of social cognition considered earlier. The Health Action framework also incorporates a feedback loop that enables it to emphasize the way in which previous experience exerts an importance influence over health-related beliefs and attitudes. Lastly, it draws attention to the influence of ‘real’ (as opposed to subjective) facilitating or inhibiting factors upon personal health actions.

Before moving on to discuss sociological frameworks of relevance to the processes caught up in the delivery and reception of school-based programmes of drug education it is useful to emphasize the main lessons drawn from by the review of social-psychological models and frameworks just concluded. It appears clear that *subjective influences* on receptivity to *pre-dispositions to health education arguments* will require prominence in the conceptual schema that is being assembled. In addition to this it would seem that an exclusive focus on the personal *values, attitudes and beliefs* that pupils bring with them to the interactions in health education lessons is too narrow. *Emotions and feelings* – about health and, more widely, about self - require emphasis too.

Sociological perspectives pertinent to pupils' reception of drug education

Two broadly sociological perspectives are reviewed in this section and provide counter-balance to the individualistic focus of the previously discussed theoretical influences on the schema. Consideration of the first leads to *social norms* being incorporated into the schema as a leading *contextual influence* on pupils' receptivity to drug education. Consideration of the second is responsible for *cultural resources* being included as another important part of the contextual backdrop to programme reception.

The social construction of risk

The question of how people respond cognitively and behaviourally to risk lies at the heart of the psychological frameworks for understanding health behaviour discussed to date in this Chapter. Such a question flows naturally from a realist conception of risks as something 'objective' and capable of measurement independent of social and cultural processes (albeit liable to bias and distortion through social and cultural frameworks of interpretation). Central to the social-constuctionist position on risk that receives discussion in the first part of this consideration of alternative frameworks to inform schema-development is a quite different set of issues.

The theorising of cultural anthropologist Douglas (1985; 1992) is stimulated by questions about why some dangers get identified as 'risks' and others not; about the operation of risk as a symbolic boundary measure; about the psychodynamics of people's risk responses and

about the situated context of risk. For the sociologists Beck (1992) and Giddens (1990, 1991) the ways in which the concept of risk is related to the conditions of late modernity and to the way that risk is understood in different socio-cultural contexts are the questions of interest.

Lupton (1999) brackets the work of these three leading theorists together on the basis of a shared epistemological position on risk that she identifies as ‘weak constructionist’. From this perspective risk is as an objective hazard, threat or danger that is *inevitably* mediated through social and cultural process and which can *never* be known in isolation from these processes. A contrasting epistemology underpins the body of work inspired by Foucault’s (1991) writings on governmentality and modernity and accounts for its location at the ‘strong constructionist’ pole of Lupton’s ‘continuum of epistemological approaches to risk in the social sciences’ (Lupton, 1999: 35). From this relativist position, nothing is a risk in itself. Instead what is understood to be a ‘risk’ (or a hazard, threat or danger) is taken to be a product of historically, socially and politically contingent ‘ways of seeing’.

This conception of risk sits uncomfortably with the social realist leanings of the current research and, consequently, the work of Castell (1991) and other leading post-structural theorists on risk receives no consideration in this review. Similarly the focus within the ‘cultural/ symbolic’ perspective of Douglas and the ‘risk society’ perspective of Beck and Giddens on involuntary risk-taking (for example, linked to environmental threats) lacks direct relevance to the understanding of young people’s responses to health education and

is excluded from discussion. Weak constructionist perspectives in the area of risk and pleasure, in contrast, are highly useful to the schema under assembly. Such perspectives emphasise the symbolic meanings, created through the social world, that humans give to things and events and address the blind spot to the socio-cultural context of risk perception and behaviour that characterises the previously cognitive science frameworks for understanding health action.

Studies of American skydivers (Lyng, 1978), Australian surfers (Stranger, 1999) and, in the UK, young male criminals (Collinson, 1996), young working class males (Cannan, 1996) and female boxers (Hargreaves, 1997) highlight a range of positive meanings that may be ascribed to risk and risk taking. Voluntary risk taking, it would seem, is frequently pursued for the sake of facing and conquering fear, displaying courage, seeking excitement and thrills and achieving self-actualisation. It may also serve as a means of conforming to gender attributes that are valued by participants (or challenging gender stereotypes that are considered restrictive).

The fundamental association between risk and emotion was a key finding of a social constructionist-framed study into risk and everyday life undertaken by Tulloch and Lupton (2003) and endorses the previous decision to incorporate personal *emotions and feelings* into the schema. Interviewees were found to employ three major discourses to describe the pleasures and benefits of cultivated risk taking. The discourse of self-improvement was employed to describe the importance of working on the continuing project of self through

taking risks. The discourse of emotional engagement drew on a neo-romantic ideal of the body/self allowed to extend itself between the strictures of culture and society and the discourse of control privileged mastery over one's emotions and bodily responses as a valued aspect of engaging in risky activities. All three discourses were underpinned by contemporary ideas about the importance of identity and selfhood and led the researchers to the conclusion that risk taking is a

‘means by which subjectivity is expressed and developed according to prevailing moral and ethical values’

Tulloch and Lupton (2003: 38)

This emphasis on the values that prevail at societal level is the main rationale for incorporating *social norms* into the schema. This context-linked concept is able to incorporate the sceptical attitudes towards ‘experts’ that are identified as a characteristic feature of late modernity by social theorists working from the ‘risk society’ perspective (Giddens, 1990: 130; Beck, 1992). It also allows for the way that the working of school-based drug education programmes may be negatively effected by the social phenomenon of the growing ‘normalisation’ of adolescent recreational drug use (Parker, Aldbridge and Measham, 1998).

Structural and cultural perspectives on health behaviour

The Health Action Model goes some way to addressing the neglect of the structural (material) factors that constrain human action associated with social cognitive frameworks for understanding health behaviour. From a sociological perspective, however, it remains

vulnerable to criticism (Bunton, Murphy and Bennett, 1991) on two theoretical fronts. The first is that it is underpinned by a relatively unsophisticated conception of social structure and its reproduction. The second is that sources of resistance to health promotion strategies of persuasion and social change are omitted from its frame of reference.

Social-psychologists tend to assume that society is reproduced by the inculcation of social norms of values, attitudes and beliefs – usually transmitted by organizations – so that individuals will be adequately and appropriately socialized. Elsewhere in the social sciences the view that beliefs, values, attitudes and intentions are constructed, maintained and changed through social interaction with the environment has become increasingly orthodox and has fuelled a dissatisfaction with social psychological frameworks of health and health behaviour change. A relevant example of how health behaviour might be understood within its social context is provided by a classic study of smoking amongst women (Graham, 1984). In this study analysis of the historical and everyday contexts of women's lives established relationships between social structure and individual behaviour. Women who are disadvantaged in social class, employment and income, and who have heavy responsibilities to care for others, with few material resources to do so, develop coping strategies using cigarettes. These everyday coping strategies, though they may be damaging to the health of the households, are far from irrational: instead they play a productive role in the organization of everyday activities. Another relevant study, guided by a focus on social interaction and power relations, looked at why young people might take risks with their health (Oakley et al, 1995). The researchers found that young people have considerable knowledge about the causes of cancer but were constrained from acting

on this knowledge by their living and material conditions and their inability to take control of their lives.

Another problem identified by sociologists as stemming from the assumptions about social reproduction that underpin the social psychological approach to the study of health behaviour is that it is linked with a simplistic and essentially one-sided model of knowledge transmission (Bunton, Murphy and Bennett, 1991; Nettleton and Bunton, 1995). From this perspective health-related behaviour change is seen to emanate directly from public health initiatives, unmediated by cultural processes. Sociological thinking challenges this idea, arguing that there is a need for a more interactive and dynamic model that analyses the process of change resulting from contact between two distinct cultural groups. From this perspective, the subjects of health promotion programmes actively select, reject and adapt any incoming information or forms of persuasion; in the process they significantly shape their own socialization by drawing upon their own cultural resources (Bunton, Murphy and Bennett, 1991).

A detailed study of how youthful drinking behaviour is maintained within sub cultures provides a relevant example of the way in which a sociological approach can provide illumination on young people's reactions to health education (Dorn, 1983). The author's conclusions were that pub and youth culture both act as resources to young drinkers, effectively insulating them from outside 'cultural imposition'. Health education and brand advertising imagery is selectively taken up by these cultures and made sense of from

within them and this helps to account for the indeterminate impact of health promotion initiatives upon the target audience.

The implication of the sociological insights discussed above is that the *cultural resources* that young people draw on in the drug-related interactions that take place at the chalk face needs to be considered as an aspect of the contextual backdrop to the reception of school based programmes of drug education.

2.3 Provisional schema of influences on the processes of drug education delivery

The schema that is set out overleaf embeds key concepts from the preceding literature review into an original conceptual framework that will act as a guide for the research. In the spirit of adaptive theory (Layder, 1998) it is anticipated that the empirical data will interact with this *provisional* framework to give rise to new insights into the factors and processes caught up in the delivery and reception of school-based programmes of drug education. It is also hoped and assumed that the approach of drawing on theoretical resources from a range of disciplines will ensure that there is a balanced emphasis on influences associated with different domains of social reality.

The incorporation of *negotiations behind programme plans* into the schema as a key element arises out of the review of literature analyzing policy delivery from a bottom-up perspective. It is assumed that the outcome of the political process of negotiation will

depend on a wide range of interacting variables and will lead to policies, schemes of work and lesson plans that provide the template for drug education-related provision in the school. For the sake of clarity there would appear to be a case for distinguishing between

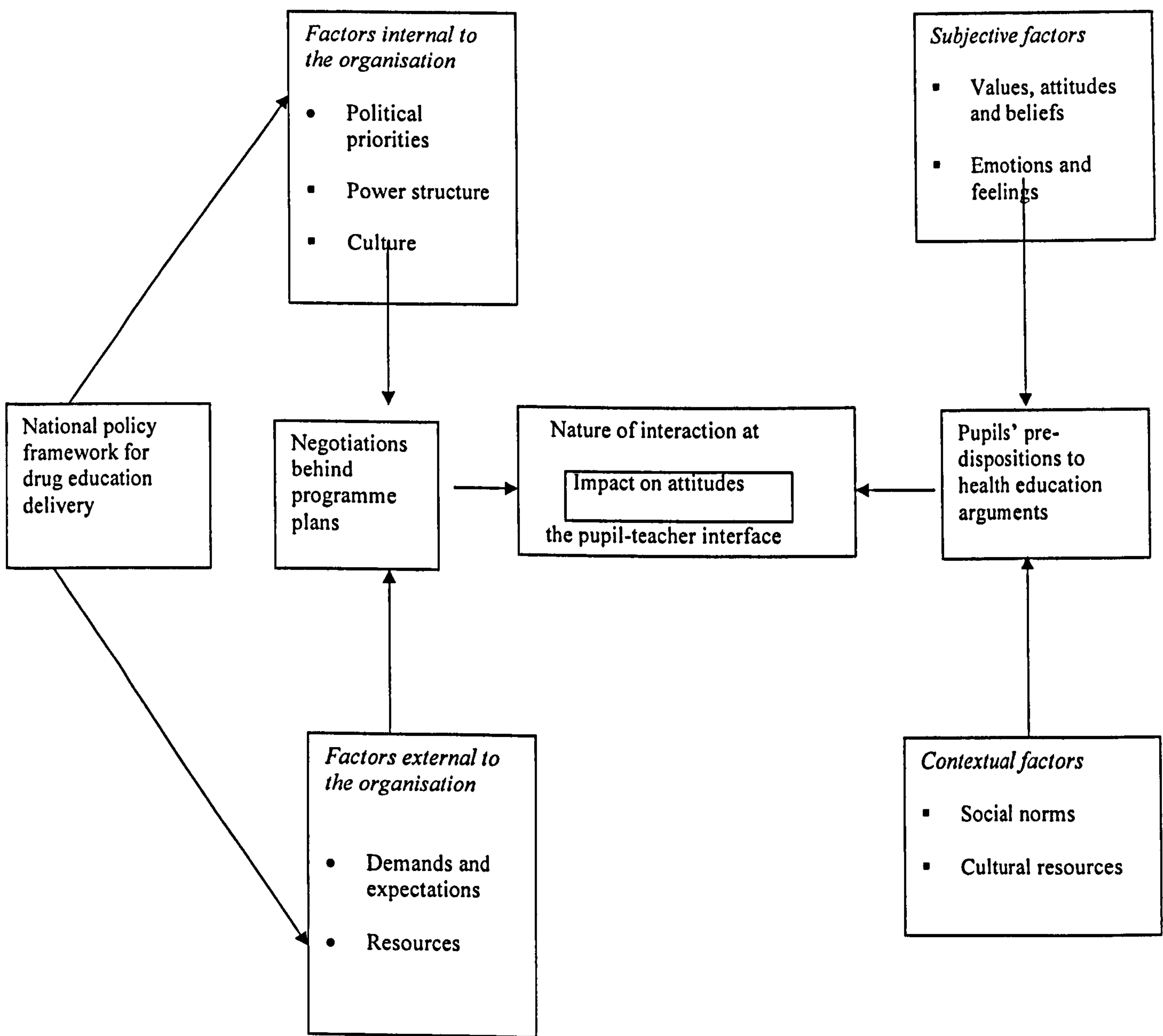


Figure 2.4 Provisional schema of influences on the processes of drug education delivery in the school setting

influences exerted by *factors internal to the organization* and *factors external to the organization*. The *culture* of a school (as reflected in the educational values of a school, the morale and behaviour of its staff members and pupils) and the *political priorities* and *power structure* that characterizes it and determines the power plays within it, fit into the first of these two categories. It is anticipated that these variables will have a bearing on the extent to which compromise on drug education ideals will take place within relevant negotiating forums. Competing *demands and expectations* on schools from all quarters and the availability of *resources* within the education system fit into the second category. The argument for incorporating them into the schema in this way is that the negotiations determining how well the blueprint for drug education within a given institution conforms to good practice principles is bound to be influenced by circumstances beyond its control. Top-down frameworks for analyzing policy implementation also had an influence on the development of the schema. This approach is associated with prescriptions for how implementing officials could be made to do their job more effectively and has a focus on whether the conditions supportive to the successful implementation of formulated (static) policy is present within the system. Issues about the adequacy of human and financial resources and of clearly communicated education policy receive a great deal of attention and already have a profile in the schema via the element of factors extrinsic to the organisation. On the assumption that the Government's actions to drive forward the delivery of good practice in drug education in schools will have a powerful impact upon the negotiations of interest, *the national policy framework for drug education delivery* is made a schema element in its own right. Various policy levers (such as statutory

requirements and inspection regimes, non-statutory guidelines and ear marked resources) employed to promote the delivery-of programmes based on ‘what works best’ are subsumed by this element.

The positioning of *interaction at the pupil-teacher interface* at the centre of the schema is based on the assumption that the quality of the match between message, source and audience factors conditions the ‘success’ of the drug education process in schools. This assumption links with the social psychology of persuasion reviewed earlier. It also fits with recognized principles of good practice in relation to the use of the media in the drug prevention context – in particular the principle that it is essential to customize media output in accordance with receiver characteristics. Influenced by the realist evaluation perspective of Pawson and Tilley (1997) the change mechanism latent in drug education programmes is conceptualized as ‘information and ideas’ (packaged into arguments) which pupils may or may not take up and act on depending on context. Although the study is focussed on the processes involved in drug education, outputs are of interest because they shed useful light on the success of a school’s chosen approach to the organisation and delivery of its drug education programme. *Impact on attitudes* is, in consequence, incorporated within the element of interaction at the pupil-teacher interface as a way of indicating whether programmes are working as hoped and intended.

The incorporation of *pre-dispositions to health education arguments* into the reception-focused part of the schema reflects the assumption that a given drug education input (video, exercise, assembly, drama-performance, outside speaker etc) is liable to be interpreted and reacted to differently by audience segments with different characteristics. This premise is congruent with insights from social-psychological models of persuasion, and can also be related to Pawson and Tilley's (1977) assumptions about the likelihood of inter-programme differences in outcomes. On the basis of individually-focussed frameworks for understanding health behaviour personal *values, attitudes and beliefs* and *emotions and feelings* are incorporated into the schema as likely *subjective* (personal) influences on receptivity to drug education messages. The relevance of context to the success of social programmes is a fundamental tenet of the realist evaluation approach and is reflected in the schema's emphasis upon *contextual* influences on the process of programme reception. On the basis of the reviewed sociological insights *social norms* and *cultural resources* are included as issues with likely relevance for the pre-dispositions to health education arguments brought to the chalk face.

In addition to highlighting elements that are anticipated to be relevant to the process and the outcome of drug education programmes in the school setting the provisional schema contains certain suggestions about the way that these elements will inter-relate. It is proposed that the *policy framework for school-based drug education* will have an indirect influence over the outcome of the school-level negotiations that produce programme plans. Change to factors internal to the organisation (e.g. priority afforded to health education,

morale of front line deliverers) is anticipated to be one way that effects are mediated. Environmental change (e.g. new demands and expectations on schools, flow of resources to support drug education in from outside) is anticipated to be another.

A right pointing arrow links *negotiations behind programme plans* to *interaction at the teacher-pupil interface*. This depicts the assumption that the blueprints for programme delivery that emerge as a result of negotiation and bargaining amongst different school interest groups will condition the quality and impact of the communication about drugs that takes place. There is, as yet, a further, unproven assumption lying behind this depicted relationship: namely, that ‘success’ of a specific programme will reflect the level of its conformity to accepted tenets of good practice in drug education.

A left-pointing arrow links *pupils’ pre-dispositions towards health education arguments* to *interaction at the teacher-pupil interface* and encapsulates the argument that the success of drug education as a process depends on how pupils react to (construe, interpret) the messages they are presented with in the context of drug education programmes. It is assumed that receptivity (or predisposition towards) drug education messages will vary between segments of the pupil audience and this is catered for in the schema via its recognition of the complexity of influences on pre-dispositions to drug education arguments brought to the chalk face.

2.4 Research questions

On the basis of the review of literature in this chapter and the provisional schema set out above, the following questions are identified as the ones to guide the empirical research.

- Are there any identifiable patterns in the impact of health education on pupils' attitudes towards substance-related risk taking?
- What is the nature of the variation among pupils? Along what dimensions does it occur?
- What factors (subjective, linked with wider social context) contribute to the variation?
- How is the influence of relevant factors on pupils' take up of drug education messages mediated?
- Are there any particular aspects of delivery that shed light on variations in pupils' reactions to drug education?
- Do negative aspects of delivery correspond to deviation from the principles of good practice conveyed in national guidelines on drug education?
- What organizational factors (internal, linked to the wider educational and social system) have significance in the decisions behind the blueprint for drug education at school level?
- What significance does the national policy framework surrounding drug education have for the actions and reactions of key stakeholders in the drug education process?

CHAPTER THREE

Methodology

The purpose of this study is the analysis of the processes occurring within programmes of school-based drug education in order to gain theoretical insight into factors that help and hinder the delivery of good practice at the chalk face. This chapter provides information about the methodology underpinning the study's empirical component. The data relating to pupils' reactions to drug education were obtained as part of a wider, ESRC-sponsored investigation into the impact of critical incidents on young people's health-related attitudes and behaviour. The author of this study was the only researcher, other than the lead researcher on this project, and was actively involved with the analysis of both the quantitative and qualitative data collected (Denscombe and Drucquer, 1999a; 1999b; 1999c; 2000). The findings relating to the negotiation, planning and implementation of school-based programmes of drug education are the product of independent research undertaken in schools. The chapter is divided into three sections. The first part describes the methods of data collection and analysis, the second part provides a rationale for the research strategy and the final section considers the main limitations of the methodology.

3.1 The Research Methods








The conceptual background to the employment of a mixed methodology strategy was briefly discussed in the previous chapter and receives more consideration in the next

section where the technical strengths of this approach are assessed. Figure 3.1 provides an overview of the way that the various methods and strategies employed were phased over the period of the fieldwork.

The survey of pupils was the first element of the overall research strategy. This took place between January and March 1997 and focussed on 12 schools in Leicestershire and Rutland – counties in the East Midlands of England [See Appendix 3 for brief profiles]. They were chosen on the basis that in terms of catchment area (social class, ethnic composition, urban /suburban/rural) they were representative of schools in the area as a whole.

The questionnaire was distributed to half of the Year 11 pupils in each school via mixed-ability tutor groups. In addition to informal suggestions about how the questionnaire was to be administered, written advice was provided to teachers specifying the procedures to be followed. Collaborating teachers were instructed to seal all completed questionnaires in the provided enveloped in front of the class in order to reassure them about the confidential nature of the research. They were also asked keep a note of the absentees on the day the questionnaire was administered and to get completed questionnaires from them as soon as possible after their return. As well as questions about the influence of school-based health education on personal willingness to take health-related risk and demographic questions, the questionnaire also included items on young people's consumption of tobacco, alcohol and illegal drugs and on their perceptions of threats to their health [see Appendix 4a]

Figure 3.1 Methods and scheduling of data collection

	Spring/summer 1997	Autumn 1997	Spring/summer 1998	Autumn 1998	Spring/summer 1999
Documents					
Questionnaires					
Focus groups					
Interviews					

Key to sources of data:

-  Schools
-  Pupils
-  Teachers

This method produced a 98.2% response rate which, though it might appear to be exceptionally high, is not unusual for surveys conducted in schools (Denscombe, 1992). There were, in the end, responses of a sufficiently high quality to use from 1648 young people. These comprised 46.4 per cent males and 53.6 per cent females. 71.2% of respondents were of White ethnic origin, 24.6% were South Asian (a category that included Indian, Pakistani and Bangladeshi) and 4.2% were Black (a category that included Black African, Black Caribbean and Black other).

After manual checking, the questionnaires were carefully scrutinized to ensure that the profile of information that they contained was consistent, plausible and sufficiently complete. Usable questionnaires were then converted into a computerized data file. The data analysis was facilitated by use of the statistical package SPSS. The first step involved the organization of the raw data on the basis of frequency distributions. The next step involved data manipulations designed to investigate possible relationships between variables. The chi-square test was applied to the cross-tabulations produced because the data was either nominal or ordinal in character and because this particular test is suitable for use in both cases. In line with statistical conventions apparent connections were only deemed to be significant if the probability of them occurring by chance was calculated to be less than 1 in 20 ($p < 0.05$).

Initial analysis revealed that the young people who responded to the questionnaire reflected a pattern of substance use that is broadly in line with the national picture for the age group

(McMillar and Plant, 1996: HEA, 1997). Nearly a third were regular smokers, two thirds were occasional/ regular drinkers, half had been drunk during the last six months and two fifths had experimented with an illegal drug on at least one occasion.

The questionnaire survey was followed up, between June and December in 1997, by focus group discussions conducted with a sub-sample of 15-16 year old pupils. In total 123 Year 11 pupils participated in 20 groups of 4-7 pupils. Two focus groups took place in each school, except one school that declined to be involved in this phase of the research citing an imminent OFSTED inspection, and two others where only one focus group proved to be possible. On the basis of different permutations in the first five focus groups held it was decided that there were no obvious differences between single-sex and mixed-sex in terms of the kind of topics that were discussed, the level of openness in discussing them or whom dominated the interaction. As a result the second researcher (the female author of this study) moderated the rest of the focus groups and teachers were asked to recruit a mixture of boys and girls. Various prompts to discussion were used, mainly drawing on the initial findings from the questionnaire survey [see topic guide, Appendix 4b]. This allowed some validation of the findings from the questionnaire, a point that will be returned to in the next section. The focus groups also provided more insights to the attitudes and perceptions of this age group and were specifically geared to revealing pupils' assessments of the value and impact of their drug education experiences. Proceedings were tape recorded and subsequently transcribed. The only exceptions were one instance when mechanical failure prevented the recording of a focus group discussion and two occasions when the levels of background noise were so high that it was impossible to decipher focus group recordings.

In this case a back-up strategy of paper recording of key points after the focus group discussion had finished was used.

Following the 20 focus group discussions a round of paired interviews was conducted (n = 20, ten interviews). These took place at five of the twelve original schools. The basis of the selection for the five was that they were diverse in terms of their catchment area and in terms of their data profiles from the survey. To provide contrast with the mixed-sex situation of the focus groups the (White, middle-aged) male researcher leading the ESRC project interviewed a pair of male pupils and the (White, middle-aged) author of the current study interviewed a pair of female pupils. These interviews allowed for more in-depth probing of young people's experiences of drug education in relation to their attitudes towards substance-related risk taking and teachers were encouraged to recruit volunteers who could be anticipated to 'speak out and voice their opinions' [see interview administration procedure, Appendix 4c]. The focus group discussions had been semi-structured, with the researcher using a schedule of open-ended questions and prompts. In comparison the paired interviews were loosely structured around a limited set of topics. It was also reflected in the flexible approach to questioning. Little attention was paid to the order in which topics were considered. More significantly there was great flexibility in respect to what was covered. The researcher supplied a broad, opening question, 'I am interested in the decisions that young people take on issues such as smoking, drinking and drug use. What considerations would you say have influenced you?' After this further questions were based on what the interviewee had said and consisted mainly of clarification and probing for detail. As before, all interviews were tape-recorded, and began with an

explanation of the purpose of the research and assurances on the issue of confidentiality. The tapes, which lasted an average 45 minutes, were tape-recorded and, subsequently, transcribed in full.

The qualitative data obtained from the focus group and interview was analyzed using an approach based on well-established premises, principles and procedures (Strauss, 1987; Strauss and Corbin, 1990; Miles and Huberman, 1994). Through an iterative process of visiting and re-visiting the transcripts a number of themes began to emerge from the data. Using an approach that was careful not to be too 'leading', themes emerging from the analysis of the early focus group discussions were checked out during the later focus groups and subsequently modified and refined.

The first data linked to the negotiation, planning and implementation of school-based programmes of drug education was collected in the Autumn term of 1998 on the basis of a survey into drug education provision in secondary phase schools in Leicester, Leicestershire and Rutland. The questionnaire was targeted at the teacher responsible for drug/health education and/or personal and social education (PSE) coordination in the school and was distributed using the internal postal systems of the three education authorities involved. In addition to items designed to provide an overview of drug-related policies and practice it also included items on teachers' attitudes about the quality of drug education in their school and an open question designed to canvas views about factors affecting the implementation of drug education policy [see Appendix 4d]. Follow-up of non-respondents boosted the final response rate to 66%. This response, although less than

ideal, is respectable in the context of postal questionnaire research and compares favourably with the 62% response rate achieved in the national survey on drug education in schools carried out in the previous year (OFSTED, 1997).

Different response rates were achieved within the different categories of schools included in the survey. The highest response was obtained in upper schools (14-18 years) - 94% replied to the questionnaire. Secondary schools (11-16 years) achieved a response rate of 72%, whilst middle schools (10-14 years) achieved the lowest response with only 53% of the schools circulated responding to the questionnaire. The response rate amongst Secondary and Upper Schools was undoubtedly boosted by a good level of return from the 12 schools involved with the earlier phase of the research. The lower response rate in the middle schools may have reflected the fact that responsibility for the development of drug-related policy within schools catering for the 10-14 age group tends to fall to teachers (usually Heads or Deputy Heads) with a wide range of competing claims on their time. Overall, the final sample was fairly evenly balanced in terms of the different categories of schools represented within the systems of the three education authorities represented in the counties of Leicestershire and Rutland. 38% were Middle Schools (10-14 years), 34% were Secondary Schools (11-16 years) and 28% were Upper Schools/ Community Colleges (14-18 years).

Following the questionnaire, the study moved into its final phase of data collection. This involved interviews and documentary analysis used in the context of a case study strategy (see figure 3.1). The case study approach was particularly applicable to this concluding

stage of the enquiry because focus on a limited number of schools facilitated an in-depth focus on relationships and processes and, thus, addressed the research questions well. In line with recommended practice in case study research, judgements about 'suitability for the purpose' informed the selection of the case study schools (Yin, 1994). The survey had indicated that the four models of approach to drug education identified in national guidelines (DfE, 1995) comprehensively described the pattern of provision in Leicestershire and Rutland. Four schools were therefore selected on the grounds that their approaches to drug education were contrasting yet 'typical'. The fifth was selected on the grounds that it was in the process of instituting a new approach to drug education that brought it into line with the model favored by policy makers (DfEE, 1997) and was, therefore, 'intrinsically interesting' (Stake, 1995). The approach to the organisation of drug education in each of the case study schools is briefly summarized overleaf (Figure 3.2).

In each of the five case study schools decisions about the personnel to whom the researcher should have access for the purposes of interview were made by the teacher used as a contact in the previous stage of the research in consultation with the Headteacher/ Principal. In the case of Schools B and schools E this resulted in the member of staff with the day to day responsibility for planning and organizing drug education *and* the Vice-Principal with strategic responsibility for policy development in this area being interviewed. In the case of School D it meant that the drug education co-ordinator *and* the school's health education specialist teacher were both interviewed. A number of schools were working closely with their Education Authority's Drug Education Project Officer so this officer was also interviewed and asked to supply relevant documentary evidence.

Figure 3.2 Organisation of drug education in the case study schools: summary of approach

<p><i>School A (= School 2 of the original 12 schools)</i></p> <p>In this school health education is coordinated by the Head of Careers and takes place in the context of PSE. A small number of teachers with a specialist interest in health education deliver lessons on the ‘sensitive’ topics of sex and drugs; there is a heavy reliance on outside speakers.</p>
<p><i>School B (= School 4 of the original 12 schools)</i></p> <p>In this school health education (which includes drug education) is an integral part of the PSE program and is delivered by form tutors</p>
<p><i>School C (= School 5 of the original 12 schools)</i></p> <p>In this School there is no PSE program. Members of the Science faculty deliver health education inputs on the topics of sex and drugs.</p>
<p><i>School D (= School 7 of the original 12 schools)</i></p> <p>In this school health education is provided in the context of a number of subjects including P.E. and R.E. Much of the work on drugs is delivered by a teacher with a specialist interest in the topic. The school has a PSE program but health education is not a part of it.</p>
<p><i>School E (= School 9 of the original 12 schools)</i></p> <p>In recent years this school has suspended the timetable of pupils in Years 9 and 10 so that members of the Science faculty can deliver a morning-long session on the topic of drug-related health education. The approach is moving towards health education becoming a part of PSE, delivered by form tutors.</p>

A total of 9 interviews took place, the average length of which was just in excess of an hour. All interviews were tape recorded and transcribed, with the exception of the interview with the specialist health-education teacher in School D who, despite the usual assurances of confidentiality, specifically requested that the interview was carried out on an off the record basis. A loosely structured schedule of questions was used, in a very flexible fashion, to guide and shepherd the interview [Appendix 4d]. In each case study school the aim of the interview was the same: to obtain rich insights into the factors and processes shaping the delivery of drug-related policies and programmes.

Over the same period during which the interviews with teachers were taking place, relevant documents were being obtained from the five case study schools for evaluation and analysis. These included drug/ health education policies, other relevant organizational policies (smoking/ dealing with drug-related incidents), schemes-of-work, lesson plans and lists of resources. This exercise enabled teachers' verbal accounts of drug-related policies and programs to be cross-referenced with the accounts enshrined in official documents. In addition to extending the data this operation provided a means of establishing its validity.

3.2 The Research Strategy

The rationale for the mixed method design

The decision to employ a combination of different research methods and approaches reflects the conceptual influence of realist evaluation (Pawson and Tilley, 1997) and

adaptive theory (Layder, 1998) on the research. These approaches operate from the position that social reality is ontologically plural and favour multiple data sources and collection techniques on the grounds that they allow researchers to gain a stronger and more sophisticated analytic purchase on the interconnections between macro and micro features of the social world.

The decision also reflects rejection of the idea that there is something fundamentally incompatible between quantitative and qualitative methods and acceptance of the argument that there is great advantage to be had in a combination of methods with complementary strengths and weaknesses (Brewer and Hunter, 1989). In this study the ability of quantitative techniques to furnish a broad overview picture based on numbers and 'hard' evidence of connections is prized as way of offsetting the limits of the descriptive data generated through focus groups and interviews. By the same token, the ability of qualitative techniques to promote rich and in-depth understanding of participants' personal experiences of drug education, based on their own categories of meaning, is seen as a productive way of offsetting the survey's approach of imposing pre-determined categories on the researched. Denscombe (2003) suggests that the key disadvantage to the use of multi-methods is that researchers will almost certainly need to sacrifice some areas of investigation that could have been included in order to free up the resources that this approach requires. Offsetting this he identifies two important benefits. The first is that having access to different kinds of data on the same topic allows the researcher to understand the topic in a more rounded and complete fashion than would be the case if the data had been drawn from just one method.

The second relates to the way that the use of multiple methods promotes the validation of data through triangulation.

The concept of triangulation is borrowed from the field of nautical navigation where it relates to the way in which a 'true' position can be located by reference to two or more coordinates. In the context of social research the concept translates into the idea that there is value at coming at a topic from a number of different angles and checking findings against each other. In this research it is not presumed that the use of methodological triangulation can prove that data or analyses are absolutely correct. Instead a cautious position is taken characterized by an interest in the extent to which findings associated with different methods corroborate each other or converge.

The sequential nature of the research

Using an approach to categorizing mixed method designs developed by Tashakkori and Teddlie (1998 p 43) the study's design can be described in the following terms:

quan/ QUAL and quan/ QUAL

Two essential features are highlighted in this summary: first that emphasis in the study was on qualitative approaches, second that the study was a sequential one, characterized in both its stages by the fact that a quantitative phase of data collection was followed by a qualitative phase. The decision to use this particular model of mixed methodology design reflected the judgement that it provided a good fit with the study's exploratory purpose and underlying inductive logic. Quantitative data were valued not because they could help

support or disprove a pre-determined hypothesis but because the associations and relationships that its analysis could, potentially, reveal could provide useful 'leads' for follow up within the qualitative data collection stage. As a result it could enhance the illumination of drug education and increase the likelihood that useful theoretical insights into its workings might be generated by the study.

The fact that pupils' interpretations of, and reactions to, drug education was investigated in stage one of the study, and that investigation of schools' delivery of drug-related policies and programs was not embarked upon until stage two, reflected the researcher's circumstances during the first two years of the fieldwork. Employment as research fellow on the *Critical Incidents and the Health-Related Behavior of School Children* project afforded an ideal opportunity to pose the questions to pupils that the research demanded. Equally importantly it enabled the researcher to build up good working relationships, inside schools with teachers and managers responsible for health/drug education. (It was recognized that although this could not guarantee that teachers/ schools would be willing to co-operate with the next stage of the research, the investigation into the provision and delivery of drug education at school level, it would go some way to encouraging continued collaboration). Good relationships were nurtured by ensuring that those collaborating with the enquiry into pupils' health-related attitudes and behaviors appreciated that their support had been valued and felt that they had been given something back in exchange. A once-a-term newsletter was circulated to all Heads/Principals and all contact teachers presenting key findings from the quantitative phase of the study. Reports were sent into each school in which their own results were compared with the findings based on the pooled survey results as well as with

findings of national studies. In addition, an offer was made that, if desired, the researcher would come into school to present both qualitative and quantitative findings to personnel involved with drug education delivery.

Ethics

The strategy in relation to the ethical aspects of the study was to take positive measures to ensure that the interests of the research subjects were not harmed in any way by their participation in the study. In the case of the reception-focussed stage of the enquiry, the fact that the research subjects were still minors had implications for the way in which ethical issues were handled. In the United Kingdom consent from children is usually interpreted to mean consent from parents or those in 'loco parentis' (SRA, 1988) and, as a result, access to pupils was negotiated through Head Teachers/Principals. The decision about whether to contact the children's parents to inform them about the research and giving them the option to withdraw their children if they wished to was left to the Head Teacher/ Principal. Other researchers involved with schools based projects on potentially sensitive subjects have prompted such an approach (e.g. Prendegast, 1994) but this course of action was deliberately not taken. Partly this reflected the presumption that the logistical implications of this might reduce schools' willingness to be involved with the research. Partly it reflected the view that it is possible to be overprotective on the issue of informed consent with the adverse consequence that children's potential to participate in research and 'have their views represented in the policy is, consequently, reduced (Morrow and Richards, 1996). Only in School E was it decided that parents should be circulated with information on the study. The head teacher was provided with a suggested text for the letter that highlighted parents'

entitlement to withdraw their sons or daughters from the study if they so wished. In the event, no parents took up this option.

If research is to meet accepted ethical standards it is necessary to recruit subjects on the basis of 'voluntary consent'. In the case of school-based enquiry, however, it has to be acknowledged that there are 'institutional pressures' on pupils to cooperate which render the achievement of truly voluntary consent problematical (Denscombe, 1992). In light of the practical barriers to achieving 'ideal consent' it was decided to settle for 'adequate consent'. This concept has been defined by the Social Research Association as 'consent that falls short both of implied coercion and full-hearted participation' (SRA, 1989).

Although there might have been some advantages to the researchers working on a face to face basis with the pupils to secure this consent, time and financial constraints rendered this option impossible. Instead, form tutors were relied on to get over key messages. The first concerned pupils' right to refuse to participate in the survey if they wished. The second concerned the anonymous nature of the survey and the careful steps that were being taken to ensure that the information provided by respondents was only seen by the researchers. In the case of the qualitative approaches to data collection adequate consent was put into operation by ensuring that the voluntary nature of the focus groups and interviews was stressed to all prospective candidates.

In the case of the teacher-focussed stage of the enquiry, the issue of consent was less problematic because the research subjects were adults. If, for whatever reason, drug

education coordinators did not consent to the survey they had the straightforward option of not returning the questionnaire. Similarly schools which were not to act as case studies were given an opportunity in the survey questionnaire to signal their preference not to collaborate further with the research. Great care was taken when making the final selection of case study schools that consent was informed and fully voluntary.

At all stages of the research process confidentiality was an important ethical consideration. Participants had consented to the research on the basis that all the information they provided would be treated in the strictest confidence and it was therefore essential to employ techniques that would ensure this commitment was honored. The identity of schools taking part in the study was disguised by the allocation of an identifying number at the data coding stage and, in the case of the pupils' survey, the questionnaire itself was fully anonymous. In the analysis of the qualitative data participants were given pseudonyms at the data transcription stage and the names of any people and places mentioned in the course of discussion were disguised in the tape transcripts. Pseudonyms were provided for the 5 case study schools and, in the final presentation of findings, careful steps were taken to ensure that no information was included that could have led to their identification.

The consideration of validity and reliability

The qualitative and quantitative phases of the research were characterized by different approaches to establishing the validity and reliability of the results. In the case of the two surveys the accompanying research operations were designed to ensure that the data on

which inferences were based met the quality standards associated with the quantitative research tradition. From the quantitative perspective internal validity relates to the extent to which the findings correspond to reality (Kirk and Miller, 1986). Despite reassuring evidence that pupils are prepared to answer questions relating to their health-related behaviours honestly *provided* they are convinced that the research is confidential (Single 1975; Swadi 1988), the quality of the data yielded by the questionnaire survey of pupils was an issue that merited carefully scrutiny.

Missing variable analysis (SPSS) facilitated the identification of questionnaires that contained a high proportion (50% or more) of missing answers and/ or a lack of information on the key identifiers of age, sex and ethnicity, and these were excluded from the analysis on the grounds of insufficient completeness. Questionnaires where there was evidence of a deliberate attempt to mislead on the basis of spurious answers were also rejected in the belief that they might compromise the accuracy of the findings. In the end 33 of the original 1681 questionnaires were removed leaving 1648 in the sample for analysis.

In relation to the survey of pupils two observations provided additional reassurances that the findings were internally valid. Firstly they were found to be broadly in line with those obtained by two national surveys focussing on substance use practices in the 15-16 year old age group (McMillar and Plant, 1996; HEA, 1997). Secondly the overwhelming majority of focus group participants indicated that they considered the survey findings provided a plausible overview of substance use practices amongst the Year 11 pupils attending their school. In the case of the survey of drug education coordinators the main approach to establishing internal validity of findings was to evaluate the degree of consistency of the

results with previous findings in the literature. This led to the reassuring conclusion that the patterns of curriculum provision and the level of drug education policy development revealed by the survey were in line with those found in comparable local and national surveys (Leicestershire HPC, 1996; OFSTED 1997).

Reliability, from the quantitative perspective, refers to the purity and consistency of a measure: to the probability of obtaining the same results if the measure were to be repeated (Kirk and Miller, 1986). In the case of the two surveys this issue was mainly addressed by establishing that there was a high level of consistency within the profile of answers. In the case of the pupils survey an additional safeguard was the inclusion of questions which, in previous studies, had been shown to produce reliable data on the substance related practices of school pupils (Denscombe 1995).

It has been argued, on philosophical grounds, that the concepts of validity and reliability have their roots in positivism and therefore only have relevance for quantitative researchers (Lincoln and Guba, 1994). This view was rejected, however, in favour of the pragmatic analysis that qualitative researchers have an obligation to address both these issues so that judgements about the quality of the research can be facilitated (Kirk and Miller, 1986; Silverman, 1993; Miles and Huberman, 1994). In the qualitative context the challenge for the researcher is to produce a plausible and coherent explanation of the phenomenon under scrutiny. In this study 'within methods triangulation' (Jick, 1979) was the way in which this challenge was addressed. The observation that similar themes emerged in the context of both the focus groups and interview discussions with pupils provided reassurance that the

findings were trustworthy. So too did the level of agreement between teachers' accounts of drug related policy and programme aims and the statements of intention encapsulated in policy statements and other documentary data.

In relation to the issue of reliability the challenge faced by the qualitative researcher is not to show that there is a strong likelihood that the findings are stable, in the sense that another researcher would have duplicated them. Instead it is to lay a sufficiently detailed 'audit trail' (Guba and Lincoln, 1985) that the reader of the study can come to an informed judgement about whether another researcher, in the same context, would have generated similar data and would have come to similar findings and conclusions. It is hoped that the fine points of the data collection and the data analysis, as supplied in the previous section, will have provided grounds for an informed judgement of this nature in relation to the qualitative phases of this study.

Reflexivity and self

The reasons behind this study's emphasis on qualitative approaches to data collection and analysis have been previously discussed. In the qualitative research tradition it is considered good practice to reflect on the extent to which the findings are objective - the term objective having been re-conceptualized to mean 'relative neutrality and reasonable freedom from unacknowledged researcher biases' (Miles and Huberman, 1994 p 278). The challenge is not to demonstrate that the findings are uncontaminated by researcher bias, but to produce a reflexive account concerning the researcher's self and its impact on the

research. This section aims to provide such an account. Within it the use of impersonal phrasing which, up to this point, has characterized the writing is temporarily suspended.

In the context of this particular study it has to be acknowledged that my identity as a middle-aged White, female, middle-class, former health professional will have affected the research process. Inevitably the age-related power differential between myself, as an adult, and my adolescent research subjects had implications for the data collection stage in phase one because it affected the nature of our interaction. Despite my best attempts to create situations in which focus group participant and interviewees felt they could express their ideas and not be negatively judged, it is possible that some pupils 'held back' because they anticipated that I would react in a disapproving manner to what they had to say. No firm conclusions can be reached about the extent to which this possibility introduced researcher-bias into the data, but it is possible to speculate that it might have been offset by another possibility, also linked to the age-related power differential. In my introductions I invited pupils to view their participation in the research as an opportunity to get their ideas about drugs and drug education over to adults. It may have been the case that some pupils' response to this invitation was to challenge the hegemony of the anti-drug position by overstating their personal involvement with and/or approval of recreational drug use. Put more simply they may have seized the chance to 'show off' about their involvement with substance use.

The gender difference between the male participants and myself is another issue that merits consideration in relation to the quality of the data collected. The subject matter in this

particular study was not judged to be of an overly sensitive nature. Nevertheless it was decided that there was a need to check out the possibility that pupils would be inhibited about talking about certain aspects of their experience with a researcher of the opposite gender. In the case of the focus groups, early permutations (mixed sex focus group/ female researcher; mixed sex focus group/ male researcher; single sex focus groups/ same sex researcher) did not indicate that the issue of gender had a significant impact on the quality of the interaction within the groups. The lead researcher on the ESRC project therefore withdrew and I went on to moderate the remaining, mixed-sex focus discussions myself. In the case of the interviews it was anticipated the more in-depth nature of the discussion might have implications for the sensitivity of its content matter which is why my male colleague interviewed the five pairs of boys and I interviewed the five pairs of girl. Although difficult to judge, it was our shared opinion that sharing a gender with the pupils probably enhanced the quality of interaction in these exchanges because it made the interviewees a bit more confident that they were being properly understood.

The fact that a quarter of the pupils who participated in the research were of South Asian origin whilst my own ethnic identity is White will have inevitably had an impact on the research. In my personal assessment, however, there is a sense in which this ethnic difference actually enhanced the research process. When I explained my lack of understanding of religious and cultural beliefs in relation to smoking, drinking and drug use Asian pupils were very willing to explain them to me and to allow me to probe them until I understood them. Had the researcher been of a similar ethnic background it is possible that these beliefs and their meanings would have been more taken-for-granted and therefore

been less explored. Pupils also gave me the impression that they were prepared to share their liberal, personal attitudes with me because they were aware that I would not be judging them by 'traditional' South Asian standards. I was therefore privileged to hear comments that they might not have wished to share with an older Asian researcher.

In my opinion of all the facets of my identity it was my middle class status that introduced the most researcher-bias into study. The only times when I experienced difficulty in establishing a good level of rapport with pupils was when I was working with pupils in schools serving deprived, working class areas. The main context in which poor communication arose as a problem was School 03 (a school then under OFSTED special measures and subsequently closed by the Local Education Authority). The morale amongst both staff and students in this school was very low and pupils' responses to questions were guarded and often monosyllabic. My impression was that they (rightly) considered me ignorant of their social world and felt hostile to the research process.

An illustration of this is the clearly annoyed reaction of one pupil in this school to a remark I had just made suggesting that the general opinion, so far, in the research was that illegal drugs were widely available if young people wanted them.

'How on earth d'ya expect anybody can afford drugs around 'ere? '.

Focus group 1, School 3

The phenomenon of research participants telling researchers things they think they want to hear is one that I attempted to guard against in both phases of the study by emphasizing my

'neutral' status as an academic researcher and by not disclosing my previous employment as a health education specialist. In relation to the pupils' inquiry my impression was that pupils did not have the sense that they should suppress any criticisms of the drug education regarding the reception or delivery of drug education. This leads me to the conclusion that my personal background was not a significant source of researcher bias in the context of data collection. In relation to the teachers' inquiry there remains a possibility that teachers were concerned to present their policies and practices in a good light. Generally speaking, however, it was my impression that my assurances of confidentiality had contributed to a situation in which teachers felt free to point out the problems, tensions and inconsistencies surrounding the delivery of drug education within their school.

Moving on to the data analysis stage of the research it needs to be acknowledged that my status as a former health education professional is liable to have influenced my interpretation of the qualitative data. My experience of supporting teachers in the field of health education has led me to the impression that their aims and intentions are more enlightened than pupils tended to give them credit for. I was, therefore, circumspect in my interpretation of the ways in which pupils construed their experiences of school-based drug education, and was keen to balance the pupils' perspective with that of the teachers. Because of this my research might be criticized on the grounds that it did not accept the voice of young people. In my defence I would make the point that, despite my empathy for teachers, I was open to the criticisms and negative points that I heard from pupils. I would also point to the equal weighting given to findings relating to the pupils and teachers perspectives as evidence of the balance that I tried to bring to the research.

3.2 Limitations of the methodology

As is usual in social research, the study was subject to resource constraints in the planning stage and was affected by circumstances which were beyond its control but which impinged on it during the data collection stage. This section focuses on the limitations on the generalizability of the eventual conclusions as a result of methodological compromises that were made in response to unfolding circumstances.

In the case of the survey of pupils, the decision to limit attention on two counties in the East Midlands and to focus attention on a representative sample of 12 local schools reflected two resource-related imperatives: the need to contain travel costs and the need to ensure that the time spent on data collection and data analysis was kept within manageable limits. Within the schools the strategy of administering the survey through mixed ability tutor groups was designed to provide a balanced sample of pupils and to minimize the extent to which the data was affected by selection bias. Unfortunately, the other strategy aimed at controlling selection bias and promoting the external validity of the findings did not work so well. Teachers found it logistically impossible to follow up pupils absent from school on the day the survey was administered, with the result that the findings do not reflect the attitudes and practices of excluded pupils or pupils in a pattern of taking absence from school without leave. It is therefore necessary to acknowledge that any attempts to generalize the survey findings to the 15-16 year old population in general must be accompanied by the caveat that they only reflect the attitudes and behaviours of regularly-attending school pupils. The

findings revealed significant associations between pupils' ethnicity and their consumption of substances and assessments of school-based health education. It is therefore, also necessary to recognize that the survey's conclusions can not be safely generalized to populations in which the ethnic profile regarding young people is significantly different to the one associated with the area comprising Leicester, Leicestershire and Rutland.

Time and money constraints meant that the survey of drug education policy and practice had a local rather than a national focus. The fact that only three local education authorities were involved - Leicester, Leicestershire and Rutland – also has implications for the generalizability of the findings. Comparison of the 'factual' findings with those of a previous survey based on a representative sample of schools suggests that they provide an overview of drug-related policy development and curriculum practice that is relevant beyond the boundaries of the East Midlands. No such comparison, however, was possible in the case of the findings relating to drug education co-ordinators' perceptions about the implementation of good practice in their schools. As a result, it is important to acknowledge that these may not necessarily provide a valid reflection of the perceptions of drug-education coordinators generally. Even with respect to the generalizability of the survey findings *within* Leicestershire and Rutland a degree of caution is needed. The non-response rate to the survey was 34%, a fact that may have affected the quality of the data and findings by the introduction of some systematic bias. Feedback suggested that the main reasons that questionnaires were not returned was that they failed to get into the hands of a member of staff with clear responsibility for drug education. This suggests that the picture of drug education provision in Leicester/ Leicestershire and Rutland schools painted on the

basis of the survey may be affected by an absence of data from schools with the most disorganized programmes in the local area.

In the case of the qualitative phases of the study, the extent to which methodological compromises affected the external validity of the findings remains important. In this case, however, the degree to which they undermine the wider transferability of the inferences is the issue at stake. In the first stage of the research the pupils taking part in the focus groups and interviews were purposefully selected on the basis that they provided a range of the available attitudes and experiences (smokers/non-smokers, drinkers/non-drinkers) and a balanced mix of key groups (gender, ethnicity). The fact that, in addition, teachers were encouraged to invite young people who, as well as to fitting the bill, would have ‘something to say’ can be justified ethically on the basis that ungrudging willingness to take part in the research was essential. To underpin the efficacy and viability of the research as a whole it is also necessary to acknowledge that the use of this particular selection criterion may have affected the representativeness of the participants by excluding pupils concerned to hide the nature and extent of their substance use from adults. As a result, it is safe to say that the conclusions relating to pupils’ interpretations of, and reactions to drug education can only be generalized to the wider population of 15-16 year olds if an important caveat is made. This is that the insights are based on data from young people whose willingness to share their thoughts and experiences suggests they may be avoiding forms of substance use which would place them in the ‘high risk’ category for substance misuse.

The last point about limitations on the transferability of the study's conclusions relates to the data collected from the case study schools. Here the issue is the extent to which the findings about organizational factors helping and hindering the development and delivery of good practice in drug education at secondary school level have general applicability. The previous section highlighted the fact that the five case studies provided typical instances (or in one case an intrinsically interesting instance) of the way in which schools organize their provision of drug education schools. However, the choice of which school to choose as typical from the range of potentially eligible candidates was influenced by considerations of convenience and practicality of access which have implications for the external validity of the findings. Initially it had been anticipated that case studies would be drawn from schools used in the previous stage - all four 'typical' models of curriculum provision being featured within this sample - and would involve representatives of all three of the Education Authorities in the part of the East Midlands being studied. Unfortunately, this proved impossible as a major overhaul of secondary school education in Leicester Education Authority reduced the willingness of city schools (two of whom faced imminent closure, the remainder of whom faced expansion) to put themselves forward for consideration as case study schools.

In the event the five case studies chosen were all Upper Schools attached to Leicestershire Education Authority. The fact that these schools do not take pupils until they reach Year 10 of their education inevitably places a limitation on the extent to which findings based on the case study material can be generalized to secondary phase schools in general (entry at Year 7 is the norm). On balance, however, the decision to focus on schools within one Education

Authority was a pragmatic response to a set of circumstances that could not have been anticipated at the start of the research. It also had the advantage of enabling the spotlight of research attention to fall on a particularly neglected facet of drug education, the school-based interventions provided for older pupils in their final years of compulsory secondary education.

CHAPTER FOUR

Variations in programme delivery and impact

This chapter presents evidence on two issues of central relevance to the research. The first is the impact of school-based programmes of drug education on the 15-16 year old segment of their audience. The second is the way that the delivery of programmes is approached within institutional contexts – with special reference to the implementation of good practice principles. The findings highlight some interesting associations and relationships and set the scene for the qualitative findings that are presented and discussed in the two chapters that follow.

The Chapter is divided into three sections. The first presents findings based on the survey carried out in a representative sample of schools. These highlight gender, ethnicity and experience-based patterns in pupils' reactions to school-based health education and suggest that a sensitive response to diversity is a crucial component of good practice in drug education. The second presents findings from the LEA-wide survey of drug education co-ordinators and the third deals with the analysis of documentary evidence obtained from the five case study schools. The evidence highlights the co-existence of different models of curriculum organisation for drug education within the Key Stage 4 curriculum. It also reveals a high measure of similarity between schools with regard to key issues like leadership, resources (allocated timetable time), content and teaching approaches

4.1 Findings from the survey of pupils

The findings under consideration in section 4.1 are based on pupils’ *self-assessments* of the impact of school-based health education on their personal willingness to take risks with health. Before relating these self-assessments to various receiver characteristics, it is useful to establish that 31% of respondents (n = 483) were of the opinion that this willingness had been markedly influenced by health education intervention while 69% (n = 1067) were of the opposite opinion. Table 4.1 provides information that facilitates comparison with findings that relate to the impact of other potential sources of influence on pupils’ attitudes towards health related risk taking.

Table 4.1 Impact of potential sources of influence on pupils’ attitudes towards risk taking: a ranking to reflect power of influence

Marked impact	Both sexes (%)
T.V. programme viewed at home	37.8
Accident/death/illness of a relative	37.6
Accident/death/illness of someone else	31.7
Health education at school	31.0
Illness/accident to self	26.7
Witnessing a serious accident	21.6

This data helps in the interpretation of a finding that lends itself to rather negative casting. Less than a third of respondents indicated that health education had influenced their attitudes in a sphere of crucial relevance to ‘healthy, informed’ decision-making – an indication of poor performance on the part of the programmes of health education to which respondents had been subjected. To put this in context, however, school-based health education is not the only influence to be associated with a minor impact (see Table 4.1).

Even top-ranked television, a channel of communication with high appeal to the age group in question, appeared to be low on power of influence in this area.

Demographic patterns of impact

Analysis of the data with a view to ascertaining whether the impact of school-based health education varied along demographic lines was performed in order to explore the schema-based suggestion that social context will exert a strong influence over pupils' subjective *pre-dispositions to health education arguments*. Statistical manipulation of the data revealed no statistically significant patterns association between respondents' self-assessments of the impact of health education on their personal willingness to take risk with health and social class (as assigned by either mothers' or fathers' occupation). In contrast, definite differences between sub-groups were in evidence when the important social structure-linked variables of gender and ethnicity were brought into the analysis.

Table 4.2 highlights a gender difference in pupils' reactions to school-based health education. A third of female respondents (33%) stated that this intervention had had a marked impact on their willingness to take risks with their health. The corresponding figure for male respondents was significantly lower (29%).

Table 4.2 Assessment of health education's impact on willingness to take health risk by gender

	Male		Female		Total	
	No	%	No	%	No	%
Marked impact	210	29.0	272	33.0	482	31.1
Not a marked impact	515	71.0	553	67.0	1068	68.9
Total	725	100.0	825	100.0	1550	100.0

Chi-Square = 28.888, df=1, p = 0.05, 0 cells have expected count less than 5

An even more striking association was discovered when the data on impact of health education was analysed by data on respondents' ethnicity (Table 4.3). Over 40% of the South Asian pupils in the research considered school-based health education had had a marked influence over their willingness to take health risks compared with a figure of 27.1% for White respondents.

Table 4.3 Assessment of health education's impact on willingness to take health risk by ethnicity

	White		South Asian		Total	
	No	%	No	%	No	%
Marked impact	298	27.1	155	40.8	453	30.6
Not a marked impact	801	72.9	225	59.2	1026	69.4
Total	1099	100.0	380	100.0	1479	100.0

Chi-Square = 24.848, df = 1, p = 0.000, 0 cells have expected count less than 5

The explanation for the exclusive focus on the White and South Asian pupils is that Black pupils were excluded from the analysis on the grounds that the total in this category was so small (n = 69: 4.2%) that meaningful statistical conclusions would have been threatened by low numbers in cells. In analyses where ethnicity was not an analytical factor data from pupils in all three of the ethnic groupings was used.

Patterns of prevalence in substance use

As a back cloth for presentation of the findings obtained from the cross analysis of data on reactions to health education in relation to personal experience of smoking, drinking and illegal drug use (see Tables 4.8 – 4.11) an overview of substance use within the survey population is provided. Because data of this type is always more meaningful if it placed in

a comparative context the relevant tables of results include data from two contemporaneous surveys of substance use within the 15-16 year old age group. Another advantage of including this information is that the broad similarity between the findings from the current study and those undertaken by Plant and Miller (1996) and the HEA (1997) increases confidence in the data that feeds into the next phase of the analysis. [On a technical note, differences in the ways that the questionnaires were constructed means that there are some variations in the ways that categories have been defined between the three surveys. These are highlighted in notes at the end of the chapter ⁱ]

Levels of smoking

Table 4.4 indicates a very similar level of smoking for boys and girls in the East Midlands survey.

Table 4.4 Category of Smoker						
	East Midlands schools survey n=1648		National survey Miller/ Plant 1996 n=7722		National survey H.E.A.1997 n=2114	
	Male (%)	Female (%)	Male (%)	Female (%)	Male (%)	Female (%)
Non-smoker	72.3	73.3	---	---	---	---
Occasional smoker	6.8	5.6	32.1	39.6	---	---
Regular smoker	20.9	21.2			15.0	24.0
Total	100	100	100	100	100	100

This contrasts with the picture in the two national surveys, both of which discovered a higher level of smoking amongst the girls in their samples. The level of smoking in the East Midlands sample is somewhat lower for both sexes than the levels obtained in the Miller and Plant survey. More boys in the East Midlands survey smoked on a regular basis

than was the case in the H.E.A survey. The proportion of girls smoking regularly in the East Midlands sample, however, was less than that found in the HEA survey.

Levels of drinking

Table 4.5 shows that in the East Midlands survey, the proportion of pupils drinking alcohol on an occasional basis is similar for the two sexes. Girls are more likely than boys to be non-drinkers whilst boys are more likely to indicate that they are regular drinkers. The findings of the Miller and Plant survey show the same tendency for boys to be more likely to report that they drink on a regular basis than girls; the overall proportion of pupils in this category was lower, for both sexes, than that obtained in the East Midlands sample. The H.E.A. survey combines results for boys and girls on the basis that it did not detect any particular differences between the sexes in terms of drinking patterns. Comparison of results again indicates a greater level of drinking in the East Midlands as opposed to the national sample.

Table 4.5 Category of Drinker					
	East Midlands schools survey n= 1648		National Survey Miller/ Plant 1996 n =7722		National survey H.E.A. 1997 n =2114
	Male (%)	Female (%)	Male (%)	Female (%)	Both sexes (%)
Non drinker	42.7	51.9	---	---	56
Occasional drinker	30.9	31.8	---	---	
Regular drinker	26.5	16.4	15.4	11.0	44
Total	100	100	100	100	100

Levels of drunkenness

Table 4.6 shows that girls are slightly more likely than boys to report that they have been drunk on one occasion only in the last six months, whilst a slightly higher proportion of boys reported having two or more experiences in the last six months. Broadly, though, the level of reported intoxication is fairly similar for the two sexes. The Miller and Plant survey did not put a time limit on recall, but questioned pupils about whether they had ever experienced intoxication. The findings obtained higher levels of reported drunkenness for both sexes, than was the case in the East Midlands sample with girls slightly more likely to report having been intoxicated at some time than boys. The HEA survey, which also looked at whether respondents had ever been drunk, found no real differences by sex within their sample. A higher proportion of pupils in this survey had experienced intoxication, either once or on more than one occasion, than was the case in the East Midlands survey

Table 4.6 Frequency of getting drunk

	East Midlands schools survey n= 1648		National survey Miller/ Plant 1996 n=7722		National survey H.E.A. 1997 n=2114
	Male (%)	Female (%)	Male (%)	Female (%)	Both sexes (%)
Never	38.5	39.9	22.7	21.5	25
Once	14.7	16.4	77.3	78.5	19
Two or more times	46.9	43.7			55
Total	100	100	100	100	100

Levels of illicit drug use

Table 4.7 shows that boys in the East Midlands sample were more likely to report that they had taken an illicit substance (solvents, cannabis, dance drugs, ‘other’) than were the girls.

The same trend was found in the Miller and Plant survey, although for both sexes the proportion indicating that they had taken an illicit substance was higher than was the case in the East Midlands sample. In the HEA survey, it was girls who were more likely to report having used an illicit substance than boys, and again overall levels of drug use were higher than those found in the East Midlands survey. In all three surveys cannabis was the most frequently mentioned illegal substance by a very considerable margin.

Table 4.7

Use of illicit substances

	East Midlands schools survey n=1648		National survey Miller/ Plant 1996 n=7722		National survey H.E.A. 1997 n=2114	
	Male (%)	Female (%)	Male (%)	Female (%)	Male (%)	Female (%)
Yes	34.8	28.1	45.0	39.8	41.0	44.0
No	65.2	71.9	55.0	60.2	59.0	56.0
Total	100	100	100	100	100	100

The levels of substance use discovered in the three surveys compared in Tables 4.4, 4.5, 4.6 and 4.7 do not correspond in all respects. The exercise of comparison does, however, give a measure of reassurance that levels of smoking, drinking and drug use within the population of 15-16 year olds who took part in this study were broadly in line with national levels. The findings in the remainder of this section represent the result of cross analyses between data on the (self-assessed) impact of health education and data that facilitated differentiation between pupils on the grounds of their personal experiences of smoking, drinking and illegal drugs. This analysis reflects the schema-based anticipation that such experiences will have a psychological impact on the predispositions to health education arguments that pupils bring to drug education lessons.

Experience-related patterns of impact

Smokers versus non-smokers

Table 4.8 shows that smokers were significantly *less* likely to consider that school-based health education had a marked influence on their willingness to take personal risks with their health than their non-smoking peers. This finding accords with the prediction that could have been made on the basis of common sense. It also endorses the schema-based emphasis on the *pre-dispositions to health education arguments* that pupils bring with them to the chalk face. Smokers are likely to be far more aware of counter-arguments to the anti-smoking message than pupils who have never experienced the ‘pleasures’ of the consumption of tobacco at first hand. Consequently, they are liable to be more resistant to the influence of persuasion. The factors caught up in smoking choices, on the basis of this argument, becomes a pertinent focus for enquiry in the qualitative phase of the research that follows.

Table 4.8 Assessment of health education’s impact on willingness to take health risk by smoking category

	Non-smoker		Occasional smoker		Regular smoker		Total	
	No	%	No	%	No	%	No	%
Marked impact	364	32.4	40	42.1	77	23.5	481	31.1
Not a marked impact	759	67.6	55	57.9	251	76.5	1065	68.9
	1123	100.0	95	100.0	328	100.0	1546	100.0

Chi-square = 15.1680, df= 2, p = 0.001, 0 cells have expected count less than 5

Before moving on to consider patterns in the data when impact of health education is cross-analysed against data on pupils’ drinking practices, data is presented highlighting patterns in smoking behaviour between different sub groups of respondents. The data in

Table 4.9 shows that respondents in the White female sub-group were the most likely to be smokers (almost one third of such respondents smoked on a regular or occasional basis). Then came the White male sub-group (30% were regular or occasional smokers) followed by the male Asian sub-group (just under a quarter smoked), followed by South Asian female less than an eighth of whom (11.8%) smoked cigarettes on a regular or an occasional basis.

Table 4.9

Smoking by sex and ethnic sub-group

	White males		South Asian males		Total	
	No	%	No	%	No	%
Non smoker	376	70.4	132	77.2	508	72.1
Occasional smoker	38	7.1	11	6.4	49	7.0
Regular smoker	120	22.5	28	16.4	148	21.0
Total	534	100.0	171	100.0	705	100.0

Chi-Square = 18.337, df= 2, p = 0.201, 0 cells have expected count less than 5

	White females		South Asian females		Total	
	No	%	No	%	No	%
Non smoker	415	67.9	203	88.3	618	73.5
Occasional smoker	37	6.1	11	4.8	48	5.7
Regular smoker	159	26.0	16	7.0	175	20.8
Total	611	100.0	230	100.0	841	100.0

Chi-Square = 34.439, df=2, p = 0.000, 0 cells have expected count less than 5

These findings reinforce the schema-based inference that contextual influences (social norms, cultural resources) are likely to be pertinent factors. At this stage it is possible to

conclude that South Asian pupils, in particular girls, tend to be non-smokers and are heavily over-represented in the group who consider that their willingness to take risks with their personal health has been markedly influenced by school-based health education.

Drinkers versus non-drinkers

When data on impact achieved by health education was analysed against drinking behaviour no significant association was found. When the experience of drunkenness was brought in to the equation it became evident that ‘controlled’ drinkers/ abstinent pupils were prominent in the minority of respondents considering that school based health education had had a marked impact on their willingness to take risks with their health (Table 4.10).

Table 4.10 Assessment of health education’s impact on willingness to take health risk by drunkenness

	Never drunk		Once in last six month		Twice or more in last 6 months		Total	
	No	%	No	%	No	%	No	%
Marked impact	210	34.8	75	30.9	193	27.7	478	31.0
Not a marked impact	393	65.2	168	69.1	504	72.3	1065	69.0
	603	100.0	243	100.0	697	100.0	1543	100.0

Chi-square =7.701, df = 2, p = 0.021, 0 cells have expected count less than 5

This finding reflects the emphasis placed on the dangers of binge drinking within the alcohol element of the health/ drug education curriculum. Pupils with experience of drunkenness will have a higher, experience-based awareness of counter-arguments to the message that binge drinking should be avoided than their peers who stay sober. In consequence they will be less motivated to modify their attitudes or practices in the risk-reducing directions that health education programmes aim to encourage.

Further evidence to support the schema-based analysis that the substance-related actions and reactions of pupils needs to be understood in social context was obtained when the data on drinking and experience of drunkenness was analysed by gender and ethnicity. Males and females from the White ethnic majority were significantly more likely to drinker on an occasional or regular basis than their gender counterparts from the South Asian minority. They were also more likely to have been drunk on one or more occasions in the last six months. Alcohol-related norms are different for men and women within South Asian culture and this was reflected in the differences uncovered when comparisons were made between the sexes *within* the South Asian sub group (see next two tables).

Table 4.11 Drinking by sex and ethnic sub-group						
	White males		South Asian males		Total	
	No	%	No	%	No	%
Non-drinker	146	27.2	148	89.2	294	41.9
Occasional drinker	210	39.2	7	4.2	217	30.9
Regular drinker	180	33.6	11	6.6	191	27.2
Total	536	100.0	166	100.0	702	100.0

Chi-square = 199.995, df = 2, p = 0.000, 0 cells have expected count less than 5

	White females		South Asian females		Total	
	No	%	No	%	No	%
Non-drinker	223	36.6	211	92.1	434	51.8
Occasional drinker	257	42.2	10	44.4	267	31.9
Regular drinker	129	21.2	8	3.5	137	16.3
Total	609	100.0	229	100.0	838	100.0

Chi-square = 205.676, df= 2, p = 0.000, 0 cells have expected count less than 5

Table 4.11 highlights high levels of abstention amongst the Asian pupils (89.2% and 92.1% in the case of boys and girls respectively) and suggests that traditional cultural norms in relation to alcohol consumption continue to exert strong influence on the practices of 15-16 year olds members of this population sub-group.

Table 4.12 spotlights different rates of experience of drunkenness between and within pupil sub-groups and adds some further weight to this suggestion.

Table 4.12 Drunkenness by sex and ethnic sub-group						
	White males		South Asian males		Total	
	No	%	No	%	No	%
Never drunk	121	22.7	147	86.5	268	38.1
Once or more	86	16.1	14	8.2	100	14.2
Twice or more	327	61.2	9	5.5	336	47.7
Total	534	100.0	170	100.0	704	100.0

Chi-square = 199.995, df= 2, p = 0.000, 0 cells have expected count less than 5

	White females		South Asian females		Total	
	No	%	No	%	No	%
Never-drunk	135	22.2	196	86.3	331	39.6
Once or more	121	19.9	18	7.9	139	16.6
Twice or more	353	58.0	13	5.7	366	43.8
Total	609	100.0	227	100.0	836	100.0

Chi-square = 289.257, df = 2, p = 0.000, 0 cells have expected count less than 5

A possible contributor to the comparatively high levels of drinking amongst White boys and girls - 72.8% and 63.4% respectively – is the longstanding culture of alcohol use in

British society. The qualitative phase of the investigation (see findings: Chapter 5) is liable to shed some light on this issue.

Illicit drug experimenters versus non-experimenters

By way of introduction to these findings it is worth stating that cannabis emerged as the ‘first choice’ of illicit substance for experimentation with amongst survey respondents. A quarter of respondents (25.7%, n = 423) reported that they had used cannabis in order to get ‘high’. 6.6% (n = 109) reported the use of solvents, 9.5% (n = 156) reported the use of dance drugs and 9.9% (n = 163) reported the use of drug falling into the ‘other’ category in this context.

Table 4.13 shows that pupils who have experimented with illicit substances are significantly less likely to consider that school based health education has had a marked impact on their willingness to take risks with their health than pupils who have never experimented with proscribed substances.

Table 4.13 Assessment of health education’s impact on willingness to take health risk by use of illicit substances

	Not used illicit substances		Used Illicit substances		Total	
	No	%	No	%	No	%
Marked impact	345	32.7	131	27.0	476	30.9
Not a marked impact	709	67.3	354	73.0	1063	69.1
Total	1054	100.0	485	100.0	1539	100.0

chi-square = 5.091, df=1, p = 0.024, 0 cells have expected count less than 5

Once again this finding tallies with common-sense predications and with the arguments incorporated in the schema. Awareness of counter-arguments to health education messages on drugs will be greater amongst those with first hand experience of getting high on illicit substances and is liable to make them less open to health persuasion than pupils who have avoided experimentation with this particular form of risk taking.

When the data on illegal drug use was examined in relation to pupils’ ethnicity and gender the by now familiar contrast between the practices of the White and the South Asian pupils was once again in evidence (Table 4.14).

Table 4.14 Illicit substance use by sex and ethnic sub-group						
	White males		South Asian males		Total	
	No	%	No	%	No	%
Never used illicit substances	327	61.7	136	79.5	463	66.0
Used illicit substance	203	38.3	35	20.5	238	34.0
Total	530	100.0	171	100.0	701	100.0

Chi square=18.337, df=1, p = 0.000, 0 cells have expected count less than 5

	White females		South Asian females		Total	
	No	%	No	%	No	%
Never used illicit substances	407	66.6	200	87.0	607	72.0
Used illicit substance	204	33.4	30	13.0	237	28.0
Total	611	100.0	230	100.0	844	100.0

Chi square=34.439, df=1, p = 0.000, 0 cells have expected count less than 5

Of the four population sub-groups White boys were the most likely to have used illegal substances (almost 40% had done so) followed by White girls, a third of whom indicated

that they had used a substance other than alcohol or tobacco to get ‘high’. South Asian males were more likely to be illegal drug users than their female counterparts but at 20.5% and 13 % respectively the proportions doing so were significantly lower than within the White sub-group. The qualitative phase of the research explores the factors behind the interesting patterns that emerged when data relating to programme impact was related to the receivers’ ethnicity, gender and experience of substance use. The final set of interesting patterns presented relate to experience of health education, as indicated by the curriculum model characterising delivery in the school attended.

Patterns of experience of health education

On the basis of information provided by the gatekeepers facilitating access to the pupils in the 12 schools participating in the survey it was possible to assign students into one of three categories. Those experiencing health education (including drug education) within the context of a programme of personal and social education (PSE), typically delivered by form tutors. Those experiencing health education delivered within a Science framework. Lastly, those experiencing health education delivered within an alternative framework (taught by teachers with a special interest in the subject in time ‘borrowed’ from other areas of the curriculum such as careers or RE).

Table 4.15 Assessment of health education’s impact on willingness to take health risk by model of curriculum delivery at school-level

	PSHE –based model		Alternative-based model		Science – based model		Total	
	No	%	No	%	No	%	No	%
Marked impact	289	31.7	115	32.4	79	27.8	483	31.1
Not a marked impact	624	68.3	240	67.6	205	72.2	1069	68.9
Total	913	100.0	355	100.0	284	100.0	1552	100.0

Chi square = 1.836, df = 2, p = 0.399, 0 cells have count less than 5

Cross analysis of pupils' self-assessments of the impact of health education on their personal willingness to take health risks with the type of delivery model experienced revealed no significant patterns of association (see above). This finding is noteworthy because it was somewhat unexpected (see chapter 1 for discussion of the policy consensus that has built up around the advantages of PSHE-based drug education relative to other approaches). On deeper reflection, however, it was naïve to expect that the survey would be able to provide evidence to support meaningful comparison of approaches relative to each other. The previously presented data has highlighted ethnicity as a key influence upon pupils' predisposition to health education arguments. In the absence of control for this confounding variable, differences between contrasting models of curriculum organisation, in terms of their impact as subjectively assessed, stood very little prospect of emerging.

The results in Table 4.16 bring the variable of ethnic profile of school attended into the analysis and provide further support for the conclusion that the relative merits of different delivery models of curriculum organisation can only be sensibly investigated using schools with similar social profiles. The information on which the categorisation of pupils into those attending predominantly (75% +) White schools and those attending schools with a high proportion (75% +) South Asian pupils was based was extracted from LEA documents. Two of the 12 schools in the sample fell in to the second category (schools 1 and 6, n = 283).

The concentration of positive reactions to drug education in predominantly South Asian schools which is highlighted in Table 4.16 links with the schema argument that pupils'

receptivity to drug education messages is liable to be shaped and influenced by the social and cultural contexts of their lives.

Table 4.16 Assessment of health education’s impact on willingness to take health risk by ethnic profile of school						
	Predominately White		High Proportion South Asian		Total	
	No	%	No	%	No	%
Marked impact	300	26.7	183	42.7	483	31.1
Not a marked impact	823	73.3	246	57.3	1069	68.9
Total	1123	100.0	429	100.0	1552	100.0

Chi square = 36.809, df = 1, p = 0.000, 0 cells have expected count less than 5

It also suggests that socially diverse (as opposed to mono-cultural) schools face particularly daunting delivery challenges in responding to the needs, wants and preferences of the student body with respect to drug education.

Summary of findings

- The impact achieved by health education about drugs varies along gender and ethnic lines. South Asian pupils, in particular females, are more likely to consider that school-based health education has had a notable impact on their willingness to take personal risks with their health than pupils in White sub groups
- Substance use varies along the same lines. South Asian pupils, in particular females, are more likely to abstain from smoking, drinking and illegal drug use than pupils in White sub groups
- There is an association between the impact achieved by school-based drug education and pupils’ involvement with smoking, illegal drug use and binge drinking. Pupils who abstain from these practices are more likely to consider that their personal willingness

to take risks with their personal health has been influenced by this intervention than their substance using peers.

- Because of the influence of confounding variables, little significance can be read into the finding of no significant association between the impact achieved by school-based drug education and type of delivery model experienced by pupils.

4.2 Findings from the survey of drug education co-ordinators

The findings in this section are based on the area wide survey of teachers with responsibility for the co-ordination of drug education (n = 53; response rate 62%). Early findings provide an overview of drug-related policy development and programme arrangements in the area under investigation and were obtained on the basis of questions which mirrored those employed in a survey of drug education provision undertaken on behalf of the Government's inspectorate of schools (OFSTED, 1997). The later ones relate to the relationship between drug education 'ideals' and the realities of practice at the chalk face and provide data that went on to shape and inform the qualitative phase of the case study.

Policy development

The data summarised in Table 4.17 show that within the vast majority of surveyed schools drug education provision took place against the backdrop of a supportive policy context, as recommended in national guidelines. The overwhelming majority of the 53 schools in the sample (96%, n = 50) were in possession of a new or recently reviewed written statement on drug education. A similarly high proportion, 93% (n = 49) had developed policies to

deal with drug-related incidents on school premises and most 71% (n = 37) were found to have a policy in place to discourage smoking. These findings compare favourably with the levels of policy development highlighted in a national survey undertaken for the government by OFTSED (1997). By the end of 1995-96 70% of the secondary schools in the sample had developed (or revised an existing) policy for drug education and 75% had developed one for dealing with drug related incidents. Whether or not smoking policies were in place was not investigated by this particular survey.

Table 4.17 Level of policy development				
Type of policy	Middle School (%)	Upper School (%)	Secondary school (%)	All schools (%)
Drug Education	94.7 (n = 18)	93.3 (n = 14)	100.0 (n = 18)	96.2 (n = 50)
Smoking	63.3 (n = 12)	86.7 (n = 13)	66.7 (n = 12)	71.2 (n = 37)
Drug-related incidents	90.0 (n = 18)	100.0 (n = 15)	88.9 (n = 16)	92.5 (n = 49)

The data summarised in Table 4.18 reveal that all the schools which had a formal policy on drug education had given responsibility for the co-ordination of the programme to an identified member of staff as recommended in national guidelines. In the majority of schools surveyed [54% (n = 27)] the drug education co-ordinator occupied a middle-ranking position in the organisational hierarchy of the school (i.e. Year Head or Subject Head). 30% (n = 15) of co-ordinators occupied positions within the senior executive team of the school (Deputy Head or Vice Principal) and 16% (n=18) had no position of seniority. The tendency for co-ordinators to occupy middle-ranking positions was particularly pronounced in the case of Upper Schools (Years 10-13) and Secondary

Schools (Years 7-11) reflecting the increased likelihood of drug education co-ordination falling to Deputy Heads in the High School context. These findings are broadly in line with those of the OFSTED survey (1997). This found that for drug education in the secondary sector it was unusual for co-ordinators to be in senior management positions (17% were Deputy Head teachers and 82% were Class Teachers, a category that incorporates both Heads of Year/ Subject and ‘regular’ teacher.)

Table 4.18 Status of drug education co-ordinator

	Middle School (%)	Upper School (%)	Secondary school (%)	All schools (%)
Deputy Head/ Vice Principal	42.1 (n = 8)	28.6 (n = 4)	17.6 (n = 3)	30.0 (n = 15)
Head of Year/ Subject	47.4 (n = 9)	57.1 (n = 8)	58.8 (n = 10)	54.0 (n = 27)
‘Regular’ teacher	10.5 (n = 2)	14.3 (n = 2)	23.5 (n = 4)	16.0 (n = 8)
Total	100 (n = 19)	100 (n = 14)	100 (n = 17)	100 (n = 50)

Delivery arrangements

Findings relating to the place of teaching about drug education within the Key Stage 3 (Years 7, 8 and 9) and Key Stage 4 (Years 10 and 11) curricula are summarized in Table 4.19. (The denominator used to calculate the percentage figures is the number of schools in the sample that contain the Year group in question; the numerator is the number of positive identifications of the subject as a slot for drug education delivery). In the case of Key Stage 4 (Years 10 and 11) responses indicated that there are two favoured curriculum locations for drug education. The first in PSE – the most frequently mentioned subject in connection with Year 10; the second is Science – the most frequently mentioned subjects in

connection with Year 11. The next most popular vehicle for drug education delivery was tutorial periods. Less popular vehicles, in order, were P.E, R.E and English/ Drama/ Humanities. These findings mirror those of the OFSTED survey quite closely. In this study the Key Stage 4 relevant data were not differentiated on the basis of year. 76% of schools provided drug education in a PSE context, 65% in a Science context and 52% in a tutorial context. Following this, on notably lower figures, and in order came RE, PE, English and ‘other’.

Table 4.19 Location of drug education in the curriculum

Year	Science (%)	English/ drama (%)	Tech- ology (%)	Human- ities (%)	R.E (%)	P.E (%)	P.S.E (%)	Tutorial Periods (%)	Other (%)
7 (n=38)	55.3	7.8	2.6	---	10.7	17.6	65.8	39.5	---
8 (n=38)	50.0	15.7	---	---	---	10.5	76.3	36.8	---
9 (n=38)	68.4	13.2	---	---	18.4	13.2	81.6	36.8	---
10 (n=33)	67.6	14.7	---	14.7	29.4	35.3	73.5	35.3	2.9
11 (n=33)	58.8	14.7	---	14.7	23.5	21.1	52.9	21.1	2.9

A high proportion of the respondents (n = 42) indicated that taught drug education lessons were supplemented by other approaches within their school. Assemblies were the most frequently mentioned approach. Also popular were special events (e.g. exhibitions, health fairs, tie-ins with national campaigns) and inputs by outside ‘experts’ (e.g. police, school nurses, youth workers, drama groups or QUIT project workers). The OFSTED survey did not survey schools on this issue so no comparisons with practices nationally are possible.

The findings summarised in Table 4.20 reveal that schools which afforded a high percentage of their staff (three quarters or over) the opportunity to receive drug-related in-service training were in a distinct minority 37% (n = 19). In half of the cases the proportion of staff who had received training to provide them with the information, awareness and skills stood at 25% or under.

Table 4.20 Proportion of staff who have had drug education training				
	Middle School (%)	Upper School (%)	Secondary (%)	All schools (%)
0-24%	45.0 (n = 9)	60.0 (n = 9)	47.1 (n = 8)	50.0 (n = 26)
25-74%	–	13.3 (n = 2)	5.9 (n = 1)	5.8 (n = 3)
50-74%	15.0 (n = 3)	–	5.9 (n = 1)	7.7 (n = 4)
75-100%	40.0 (n = 8)	26.7 (n = 4)	41.2 (n = 7)	36.5 (n = 19)
Total	100 (n = 20)	100 (n = 15)	100 (n = 17)	100 (n = 52)

Once more these findings are in line with the national survey carried out by OFSTED (1997) which found that only fractionally over a quarter of teachers (26%) had received training to equip them to deliver drug education.

Implementation experiences

The findings in Table 4.21 are based on respondents' opinions on the conformity of drug education practice in their school with the officially promoted principles of the time [(DfE, 1995) – see discussion in Chapter 1 and appendix I]. Results from co-ordinators in all three types of school were combined to produce the results below. In the case of two of the six characteristics associated with a good standard of provision, the evidence was positive.

Reflecting on their own experiences, almost three quarters of respondents considered ‘the school places a high value on the active promotion of the mental, physical and social health of its pupils’ and just under two thirds considered ‘staff have access to good resources to support their teaching on drug education’. In the case of the remaining four characteristics there were indications of a gap between good practice ideals and delivery realities. The proportion agreeing that ‘concerted efforts are made to inform parents about the school’s approach to drug/ substance education’ was just under a half. The proportion agreeing that ‘drug education has a strong presence within the curriculum of all pupils’ and that ‘the drug education programme is closely monitored and student feedback is taken on board’ was, in both instances, 37%. The lowest level agreement came for the statement that ‘staff are confident about the teaching skills required to deliver the drugs/ substance education policy’. Positive support for this statement was obtained in only one third of cases.

Table 4.21 Opinions about conformity with characteristics of good practice				
	Agree (%)	Neutral (%)	Disagree (%)	Total (%)
The school places a high value on the active promotion of the mental, physical and social health of its pupils	74 (n = 37)	20 (n = 10)	6 (n = 3)	100 (n = 50)
Staff have access to good resources to support their teaching on drug education	62 (n = 31)	30 (n = 15)	8 (n = 4)	100 (n = 50)
Concerted efforts are made to inform parents about the schools approach to drug/ substance education	48 (n = 24)	24 (n = 12)	28 (n = 14)	100 (n = 50)
Drug education has a strong presence within the curriculum of all pupils	37 (n = 18)	35 (n = 17)	29 (n = 14)	100.0 (n = 49)
The drug education programme is closely monitored and student feedback is taken on board	37 (n = 18)	39 (n = 19)	25 (n = 12)	100 (n = 49)
Staff are confident with the teaching skills required to deliver the drugs/ substance education policy	33 (n = 16)	33 (n = 16)	35 (n = 17)	100 (n = 49)

Analysis of data yielded by an open question, asking for factors affecting the implementation of the drug education policy strengthened the impression that the translation of drug-related plans and policy aspirations into action does not necessarily proceed smoothly at school level. Of the 38 replies received to this question, 28 highlighted factors (often more than one) with a negative impact on the task of providing drug education and only 6 highlighted factors (usually just one) with a positive impact. (The outstanding 4 were difficult to categorize – for example ‘age range and locality’). Most of the negative factors mentioned could be clearly linked to the discrepancy between ideals and delivery realities highlighted in Table 4.21. The limited time available for health education on the timetable/ within the PSE programme was mentioned most frequently and can be related to the finding that the majority of respondents (72%) were not in agreement with the statement ‘drug education has a strong presence within the curriculum of all pupils’. The next most frequently mentioned factor was the lack of resources available to support staff training on drug education. This has clear links with the finding that two thirds of respondents felt unable to positively agree that ‘staff are confident with the teaching skills required to deliver the drugs/ substance education policy’. Linking less directly were factors perceived to reduce teachers’ willingness to wholeheartedly engage with the task drug education delivery (including participation in training/support opportunities). Two main factors of this nature were highlighted. The first was the prevailing educational climate and associated work pressures on teachers. The second was the ‘sensitive’ nature of drug education as a subject. The following replies represent the most elaborate developments on these two themes.

Morale in many schools seems to be low and staff are drained. Schools, sadly, have become curriculum and assessment driven in the last few years. Staff, although keen to become ‘drug aware’ have very limited time to maintain or improve their subject knowledge. Furthermore staff work so much harder within their subject

departments that PSE is sometimes seen as an intrusion and some staff, for their own health, will only attend one meeting a week. It is hard to move forward in such a climate.

Co-ordinator from a City Community College not represented in case studies

Some teachers are reluctant to take on drug education because of its political ramifications. The schools drug education programme aims for a non-judgmental approach but there is a tension here with the moral context stressed by the government. Teachers have their own opinions, which might incline them in either direction, and by no means everyone is comfortable doing work in this area.

Deputy Head in County High School not represented in case study strategy

Limited time and funds to support drug education planning and co-ordination were highlighted by a number of respondents. Evaluation is recognized as a resource-hungry process, frequently ‘squeezed’ by the more pressing concerns of programme delivery which might explain why a majority of respondents (76%) felt unable to agree with the statement ‘the drug education programme is closely monitored and student feedback is taken on board’. Some respondents drew attention to the widespread availability of drugs in the local area as a factor that undermined drug education delivery. Others, rather ironically, were more concerned about parents’ and/or Governors’ ability to blind themselves to the social realities of drug use and in the way this impacted negatively on programme implementation. For example, one respondent commented about the unhelpful ‘perception that as a community we do not have a drugs problem – it’s not that sort of school or area’.

A lack of support for programme intentions premised on ‘ostrich attitudes’ (to use the vivid phrase of one respondent) squares with the finding that the majority of respondents (52%) were unable to agree that the institution had made ‘concerted efforts’ to inform

parents about the drug education programme. In addition to the points already covered, respondents implicated poor communication in schools of 'vast size'; lack of clarity about who had responsibility for the health education policy and teachers' worries that pupils had superior knowledge of the drug scene in less than ideal practice in drug education. Replies to this open question, unfortunately, failed to corroborate or shed further light on the finding that the majority of respondents (64%) did not consider that 'the drug education programme is closely monitored and student feedback is taken on board' in their school.

Before summarizing the survey-based findings, the two factors having a positive impact on the implementation of drug education require mention. The first involved support in relation to curriculum development and INSET from outside agencies and officers. The second concerned change to a more effective curriculum model for drug education.

Summary of findings

- The vast majority of schools with pupils in the secondary phase of their education have developed a formal drug education policy. Most also possess 'supportive' policies (dealing with drug-related incidents; smoking)
- The vast majority of schools have a teacher with responsibility for the co-ordination of drug education; in most cases these teachers occupy a middle-ranking position within the organizational hierarchy.
- At Key Stage 4 the 2 main curriculum locations for drug education delivery are P.S.H.E and Science

- Teachers who have received special training to equip them for their role in the delivery of drug education are in a minority.
- The realities of practice fall short of drug education ideals. The skill and confidence of delivery staff, the profile of drug education within the curriculum and the mechanisms to promote quality are key problem areas.
- A small number of respondents highlighted positive influences on the implementation of drug education policies within their schools. LEA-level support for curriculum development and INSET and the movement to a new model of curriculum organisation were mentioned in this connection.
- A higher number of respondents were forthcoming about negative influences on this process. The main issues raised were an academic-standards dominated educational climate and the associated work pressures on teachers, and the prevalence of ‘ostrich attitudes’ towards drug use in sections of the school community.

4.3 Findings based on documentary data from the case study schools

Deeper insight into delivery arrangements and plans for drug education at organizational level was gained from the analysis of documentary evidence (stand-alone policy statements and/or statements within school prospectuses) obtained from the five case study schools. On the basis of the comparison and contrast highlighted in three tables that follow it is possible to conclude that the differences between the delivery blueprints in the five schools are far less striking than the basic similarities.

Table 4.22 summarises findings on the aims of drug education in the five case studies, as stated in their formal policy statements. Minor variations were found, but analysis suggested that these reflected their different policy contexts as opposed to underlying philosophical differences in the way that the schools saw their educational mission.

Table 4.22 Programme aims				
School A	School B	School C	School D	School E
<p>To enable students to make healthy, informed choices by increasing knowledge, challenging attitudes and developing skills</p> <p>To foster and develop self-esteem</p> <p>To provide accurate information</p> <p>To increase understanding about the implications and possible consequences of use and misuse</p> <p>To practice the skills necessary to deal with a drug offer situation</p> <p>To seek to minimize the risks that users and potential users face</p> <p>To enable young people to identify sources of appropriate and professional support</p>	<p>Drug education is an integral part of the health education component of the Social and personal development programme the aims of which are:</p> <p>To allow the student to develop a positive self-image and a commitment to the College and the wider community.</p> <p>To promote the spiritual, moral, cultural, mental and physical development of pupils at the school and of society.</p> <p>To prepare pupils for the opportunities, responsibilities and experiences of adult life.</p>	<p>To enable students to make healthy, informed choices by increasing knowledge, challenging attitudes and developing skills</p> <p>To foster and develop self esteem</p> <p>To provide accurate information</p> <p>To increase understanding about the implications and possible consequences of use and misuse</p> <p>To practice the skills necessary to deal with a drug offer situation</p> <p>To seek to minimize the risks that users and potential users face</p> <p>To enable young people to identify sources of appropriate and professional. support</p>	<p>Drug education is an integral part of the Health Education programme the aims of which are:</p> <p>To promote a healthy lifestyle and self esteem</p> <p>To enable students to make informed and responsible choices</p> <p>To provide accurate, honest and up to date information</p>	<p>Drug education is an integral part of the Health Education programme the aims of which are:</p> <p>To promote a healthy lifestyle and self esteem</p> <p>To enable students to make informed and responsible choices</p> <p>To provide accurate, honest and up to date information</p>

Schools A and B had dedicated drug education policies and this was reflected in the specific nature of the aims. In schools D and E the relevant policy covered health education in general and, as a result, the aims were broader in nature. In School B the relevant policy statement related to PSE (a formal policy statement on drug/health education had not yet been devised) and, as a consequence, the aims were broader still. In all cases it is possible to see that the philosophical underpinnings of the programmes are those of the educational model of approach to health education (Tones, 1981). This is evident in the key aim that the programmes share in common - the encouragement of healthy (responsible) choices. It is also evident in the balanced emphasis that the programmes all give to the development of knowledge, attitudes (including attitudes towards self) and skills. The identical wording of the Drug Education statements of Schools A and C and the Health Education statements of Schools D and E is a notable feature of Table 4.22 that can be readily explained. The reason for this was that they were both based on the 'off the shelf' policy-template circulated by the LEA (Leicestershire County Council Education Department, 1995).

Table 4.23 provides information about five important facets of the organisation of drug education within the case studies. Contrasts between schools are clearly apparent but the overriding impression is one of drug education planners making their choices about how to handle delivery from within a narrow range of options. In School A drug education formed part of a broad-based health education programme. It took place in a PSHE context, was co-ordinated by the Head of Careers, and delivered by a small team of specialist teachers. In Schools B and E the organisation of drug education was similar, in that it was part of a broad health education programme and its delivery was PSHE-based, but different in that it was co-ordinated by the Head of Year 10 and delivered by form tutors. In School C there

was no PSE programme and drug education was part of a narrow health education programme, the only other dimension of which was sex education. In this school the Head of Science co-ordinated drug education and its classroom delivery was by science teachers. In School D there was a broad-based health education programme; but, instead of being delivered in the regular PSE programme, some topics were delivered in PE, others (including drug education) in a time table slot usually given over to the teaching of Humanities. In this school the Head of PE had overall responsibility for the co-ordination of health education, and the delivery of drug education was by a specialist teacher.

Table 4.23 The organisation of drug education					
	School A	School B	School C	School D	School E
Nature of health education programme	Broad-based	Broad-based	Focus on drugs and sex education only	Broad-based	Broad-based
Curriculum context for health. ed.	P.S.E.	P.S.E.	Science	Time 'borrowed' from Humanities	P.S.E.
Staff member responsible for co-ordination	Head of Careers	Head of Year 10	Head of Science	Head of PE	Head of Year 10
Personnel delivering drug education inputs	50% by Head of Careers 50% by teachers with an interest in the subject.	Form tutors	Science teachers	A teacher with special interest in health education/pastoral support	Form tutors
Assessment/evaluation	No formal assessment	Local Vocational Framework provides mechanism. Focus = skills developed in context of group research project	No formal assessment	No formal assessment Evaluation forms to gain student feedback	No formal assessment

Although there were several similarities between the drug education approach of schools B and E, they had widely different approaches to assessment. In School B the PSE programme was formally assessed and successful students were awarded a locally recognized vocational qualification; the formal assessment of skills acquired by pupils in the context of a drug-related project formed part of this assessment process. In School E, in common with Schools A, C and D, there was no formal assessment of students' learning in the drug education context. School D was the only one of the five schools that had a formalised mechanism in place for obtaining pupil-feedback on the learning experience.

Table 4.24 summarises the findings obtained from the analysis of programme handbooks and/or schemes of work.

Table 4.24 Overall programme plan					
	School A	School B	School C	School D	School E
Amount of curriculum time	7 lessons	3 lessons	4 lessons	4 lessons	2 lessons
Scheduling within Key Stage 4	5 lessons in Year 10 2 lessons in Year 11	Year 10	End of Year 10	2 lessons in Year 10 2 lessons in Year 11	2 lessons in Year 10
Aspects of drug education covered	<ul style="list-style-type: none"> Smoking Alcohol Illegal drugs 	Legal and illegal drugs	Legal and illegal drugs	Alcohol and illegal drugs	Legal and illegal drugs
Contribution by outside speakers/agencies	Police (drugs and the law) Parent of son who died from solvent abuse			Visiting drama production	Follow up of assembly presentation on smoking by QUIT

School A was revealed as the case study institution devoting the greatest amount of curriculum time to drug education (seven lessons over the course of a year as compared to

three or four in the other schools). In this school smoking, alcohol and illegal drugs were dealt with as separate topics (one, three and four lessons respectively). In the other schools the approach was more issue-based with the main emphasis on illegal drugs. School A also emerged as the one of the five with the heaviest reliance on outside contributors. School E emerged as the case study school devoting the least amount of curriculum time to drug education. In this school only two lessons were currently scheduled on the topic per year. This was supplemented, however, by the provision of a smoking-related assembly designed to tie in with the drug component of the PSE programme. In addition to this, leaflets about drugs formed a part of the information pack provided to all pupils who left the school at the end of Year 11.

Research in the field of persuasive communication (see chapter 2) suggests that the key to successful drug education lies in the sensitive adaptation of inputs in accordance with the needs, experiences, interests and motivations of the target audience. In this connection, the documentary evidence-based finding that the scheduling of drug-related inputs within health education programmes was based on a single consideration - namely, the age band which pupils fell into - has significance. Teenagers within a given Year group may differ widely in their levels of involvement with substance use, their informational needs and their preoccupations. This leads to the view that drug education in the secondary school context may be better suited to some sets of pupils than others. (The findings in the section that follow and the qualitative findings in chapter 5 reinforce this further).

Table 4.25 summarizes the information obtained from the analysis of drug education lesson plans. The lessons provided by Schools A, B, C and E were found to be broadly

similar in style. They were built around the use of a variety of interactive methods (brainstorms were particularly popular) and employed teaching resources designed to enable pupils to review and extend their knowledge, clarify their attitudes and think through ways they would deal with drug-related situations. The teaching approach in School D was very different. In this school the main emphasis was on pupils performing an investigative task in small groups. This required pupils to research the knowledge, attitudes and practices of their peers in relation to both legal and illegal drugs, to present their findings in visual form and to draw out their health and social implications.

Table 4.25 Teaching approaches					
	School A	School B	School C	School D	School E
Teaching methods	Variety of interactive teaching methods	Emphasis on investigative tasks in small groups	Variety of interactive teaching methods	Variety of interactive teaching methods	Variety of interactive teaching methods
Teaching resources	Quiz sheets, case studies, scenarios for simulation/ role play. <i>'Sorted'</i> and <i>'Alive and Kicking'</i> videos Fact sheets/ information leaflets	Briefing sheets Information leaflets	Quiz sheets, case studies, scenarios for simulation/ role play <i>'Sorted'</i> video Fact sheets/ information leaflets	Quiz sheets, case studies, scenarios for simulation/ role play Fact sheets/ information leaflets.	Quiz sheets, case studies, scenarios for simulation/ role play Fact sheets/ information leaflets

In all schools a variety of information leaflets, predominantly Health Education Authority produced, was made available to pupils as back up resources. In addition to visual resources two of the five schools (Schools A and C) used drug education videos within their drug education programmes.

Summary

The case study schools were selected because their delivery of drug education was organised in contrasting ways. When the documentary evidence was analysed, however, differences were not strongly marked. Instead, the impression was one of broadly similar provision in essential respects. Particularly striking was that in all five cases programmes:

- Aspired to encourage informed, healthy decisions through an educational approach geared to the development of appropriate knowledge, attitudes and skills.
- Favoured participatory, student-centred approaches over methods associated with a didactic style of teaching.
- Were co-ordinated by staff occupying middle ranking positions in the occupational hierarchy
- Had access to a very limited amount of time on the timetable
- Relied on birth date determined Year group as the basis for deciding the information and ideas that should be conveyed.

4.4 Conclusions

The evidence from the survey of pupils suggests that school-based programmes of drug education have a variable impact within the 15-16 year old section of the target audience. Put another way, their efforts to discourage personal willingness to take risks with health (encourage healthy, informed choices) ‘work’ for some groups of pupils and fail to ‘work’ for others. This inference is congruent with conclusions about the limited effectiveness of health education by leading effectiveness reviewers in the field of substance misuse

prevention and young people (Tobler, 1986; De Haes, 1987; May, 1991; Hansen, 1992; Dorn and Murji, 1992; White and Pitts, 1997; Health Development Agency, 2003). It also fits with anticipations based on the conceptual schema of the processes underlying programme delivery that was developed in chapter 2. The proposal that social and cultural context would have relevance for young people's reactions to drug education because it would play a role in conditioning the pre-dispositions to health education arguments brought to lessons is backed up by the findings presented here. In chapter 5 this proposition receives further empirical support from qualitative evidence that illuminates the factors and processes behind the association between gender, ethnicity, past experience of substance use and drug education outcomes.

The conceptual schema also proposed that delivery practices at the chalk face (as shaped by key decisions about approaches, scheduling, resources etc) would be a factor in the 'success' - or otherwise - of drug education programmes. Although there was a failure to find a positive association between model of curriculum organisation and success as reflected in a positive (self-assessed) impact on attitudes to risk taking this does not necessarily undermine the proposition. Failure to allow for the confounding effects of different ethnicity profiles in the schools in the sample was one issue. Even more significant was the emphasis (now recognised as misguided) that was placed on model of curriculum organisation as a means of denoting type of practice (in line with current recommendations/ not in-line). The survey of drug education co-ordinators and the analysis of documentary evidence from the case study schools shows evidence of strong similarity in the ways that schools structure, resource and approach their delivery of drug education in the Key Stage 4 context. These similarities place the relatively superficial

differences reflected in different models of curriculum organisation into the shade and endorse the focus, within chapter 6, on internal and external factors that help and hinder the implementation of principles of good practice in drug education in the contemporary context.

ⁱ Technical notes

East Midlands schools survey	
Non smoker	= never smoker, tried smoking, ex-smoker
Occasional smoker	= smoke less than 6 cigarettes a week
Regular smoker	= smoke 6-20, 20+cigarettes a week
Non drinker	= never drink, only drink on special occasions
Occasional drinker	= drink once a week/ fortnight
Regular drinker	= drink 2-3, more than 3 times a week
Miller and Plant survey	
Occasional/ regular smoker	= smoked in the past 30 days
Regular drinker	= 9 drinking occasions in the past 30 days
H.E.A. survey	
Regular smoker	= smoke every day
Non-drinker	= never drink, hardly drink at all, drink a little
Occasional/ regular smoker	= drink a moderate amount, quite a lot, heavily

CHAPTER FIVE

Drug education reception: the pupils' perspectives

This chapter presents qualitative findings about influences on the reception of drug education by pupils. The first set of themes highlights personal and contextual influences on 15-16 year olds' subjective dispositions towards arguments geared to the encouragement of 'healthy' choices. The second set of themes relates to programme shortcomings, as perceived by and experienced by the young people who make up the audience for the health education messages that constitute their content. The chapter concludes that the limited impact of drug education programmes in the secondary school setting is strongly related to the individualism and diversity of social experience that adolescents bring to the chalk face.

5.1 Factors affecting pupils' subjective disposition to health education arguments on drugs.

The conceptual schema that was developed in chapter 2 highlighted *pupils' pre-dispositions to the drug education arguments* as a productive focus for enquiry and suggested that these would be affected by a combination of *personal* and *contextual* influences. On the basis of the evidence presented here this proposition emerges as accurate. The themes presented early in the chapter relate to the individual psychology of receptivity to drug education messages. Later themes illuminate the way that factors and

processes emphasised by the discipline of sociology have great relevance for pupils' reactions to school-based drug education and help to account for the patterns discussed in chapter 4.

Attitudes to health

The finding that pupils' personal (and highly individualised) attitudes to health had an influence over their receptivity to health education arguments on drugs is based mainly on evidence from pupils involved in smoking, drinking and/or drug use. Specifically it draws on data illuminating why these behaviours were initially chosen and then maintained in the face of knowledge that they carried an element of health risk. Health education programmes tend to be premised on the assumption that people have a strong investment of interest in their future health. Judging from sentiments expressed by many of the pupils in the research, this assumption is not really plausible. The following extract provides a typical flavour of comments showing disinclination to engage with messages highlighting threats. Such threats seem very remote, and therefore non-meaningful, from a young person's perspective.

Moderator: ...do you think that young people care about the health risks of smoking

Claire: Not as much as they should.

A few: No.

Marie: No one really cares because it's in the future.

Denise: Like we was walking here the other day and we was talking about it, and we says one more cigarette - this is going to take another five minutes off your life. Five minutes is nothing.

Moderator: Right. I'm presuming, but I'm sure you have been told - about the links between smoking and health problems?

All Yeah.

Moderator: So you reckon that you've got all the information.

All Yeah

Moderator: But in the case of young people, is it that these ideas about the long-term effects don't influence them very much?

Claire: You don't think about them.

school 07, focus group 01, 3 males, 3 females, all White 25/11/97

The argument that young people were in possession of the 'facts' about the dangers of drugs was encountered time and again in the research. Clearly attitudes to health were only one of the factors behind personal conclusions that would be considered ill judged from a professional perspective. There were instances, however, when studied indifference to the prospect of a long life (an aspect of health often central to arguments about substance-linked dangers) did 'leap out' from the data as a major impediment to message take up. Dylan, a White male featured in the focus group excerpt below, provides a case in point.

Moderator: You've got your whole lives ahead of you - but do you ever think about what you are going to die of?

Dylan: I've thought that - being the sort of person I am - I will probably die of taking a drug. I'll probably try something for the first time, and it will probably kill me. But I'm willing to do that.

Kimberley: I think personally I'm going to die in my own sleep, of old age, because I don't take drugs, I don't drink in excess.

Moderator: So that's what you are aspiring to - death when you are old?

Kimberley: Yeah.

Dylan: I don't want to live to an old age. You see old people on the bus, and they're like shadows of their former selves. I think possibly if I died at 50 I wouldn't mind.

Collette: Although, having said that, my granddad is over 70 nearly 80, and he still has one of the fullest lives I know. He gets more exercise than I do.

Adam: I want to die before I get to the stage when I can't actually do anything. Like when you depend on everyone else. I don't want to be a vegetable.

school 5, focus Group 02, 2 males, 2 females, all White, 16/4/97

Dylan's remarks may need to be seen in the context of a desire to shock but this does not detract from the implication that can be drawn from them. Namely that health education

messages highlighting the *costs* of drug use for *future* health are not likely to strike a chord with young people with a strong orientation towards the gratification of needs in the present. For pupils with high levels of investment in their future health and a 'responsible' attitude towards it's protection, the reverse is likely to be true. Kimberley in the extract just featured provides an example of a young person whose favourable dispositions to drug education arguments appeared to be founded on the subjective view that health was something that could not be safely 'diced' with.

The gambling analogy applies equally well to an interesting sub-group in the research – pupils who identify themselves as 'social-smokers'. Typically these young people accepted that the consumption of tobacco represented a risk to health. Indeed, their comments suggested that their strategy of limiting smoking to social situations was based on the view that they needed to stay in control of their habit in order to 'easily' quit when the 'odds' of avoiding harm were no longer in their favour. The possibility that such smokers were relying on a misplaced confidence in their abilities to control their smoking habit and/or give up easily at a point in the future needs to be recognised. This does not, however, detract from the point that a sense of health as temporarily 'safe' has real effects on young people's identification with (and interpretation of) communications about risk that stress serious consequences such as death or illness that mainly affect people in mid or old age. Young people who were willing to tolerate a degree of 'calculated risk' had different ideas about how far into the future it would be until they needed to reappraise their behaviours. In the following extract Rob suggests that most people feel they can delay taking their

health seriously until middle age. In other focus groups discussions the twenties, the thirties or, more vaguely 'when I get settled' were mentioned.

Moderator: Do you think it will be like a passing phase, do you think people grow out of it?

Rob: No. Not many until about forty.

Cath: I think I will. I don't think I'll grow out of smoking or drinking, but I have done harsher drugs, with my friend and I've grown out of that already. I don't do it now.

school 10, focus Group 02, 2 males, 3 females, 4 White, 1 South Asian, 10/11/97

In the context of the study as a whole Cath was rather unusual in the sense that the knowledge in her possession about the health risks of Class B drugs had not deterred her from seeking them out and experimenting with them. Later on in the focus group she revealed that it was an unpleasant experience of an attack of paranoia (a 'para'), when high on amphetamines, that accounted for her decision to limit her consumption of substances to tobacco, alcohol and cannabis. The critical nature of this experience, in terms of the development of her drug career, offers an introduction into the next, closely linked theme.

Critical incidents

There were a number of other occasions when pupils in the research highlighted a personal or vicarious experience that had acted as 'critical incident' in the sense that it had heightened their sense of the dangers of substance use and made a notable impact on their behavioural intentions. [The links between the personal experience of a critical incident and the substance related attitudes and practices of the young people making up the population of this study is given a comprehensive coverage elsewhere in the literature (Denscombe and Drucquer (1999)). Comments illuminating the background to anti-

smoking attitudes were the richest source of such insights, followed by reflections on why 'hard' drug use was being avoided. The following extract highlights the impact of an experience that quite a few non-smokers in the research talked about

Sheila: ... my step-grandad, he died of some illness that he got because he had smoked all his life. So I found that very upsetting, and it put me off smoking.
Helen: Same with me. My granddad died of lung cancer, and we all just had to watch him die and it was really awful (shudders) so I'm never going to smoke.

school 4, focus group 01, 3males, 3 females, all White, 5/2/98

Comments below further illuminate the positive impact on an individual's motivation to take up and act on the anti-smoking message that can result from personal experience of witnessing a family member or friends coming to harm through their consumption of tobacco.

Adam: Well one of my brother's best friends – his mum smoked a lot and she had a leg amputated.

Moderator: And do you think that really affected you in terms of your decision (not to smoke)?

Adam: Yes, and also my mum. This is why I want her to give up. She sometimes will wake up in the middle of the night, she says she can't breathe. And she's had bronchitis, and she said 'I'm never going to smoke again.' And as soon as it went away, as soon as her bronchitis stopped she went back on to cigarettes again – and every three months or so she'll get it back.

Kimberley: My mum's sister died of cancer, actually. But I only ever met her once or twice or something. I think she smoked a lot. But I think it's common sense more than anything. When you see, like, your friends from primary school and, like, they smoke like a chimney, and the way they have changed, it's like ... I don't want to be like that. My Gran always used to say 'If God had wanted you to smoke, he would have given you a chimney in the back of your head.' I've always thought of that – and it's true isn't it? I think that may have influenced me.

school 05, focus group 01, 2 male, 2 female, all White, 16/4/97

The prominent place of older relatives in accounts with a smoking-related critical incident thread is unsurprising given the way that the ill effects of smoking are concentrated in the

older age bands of the population. In the case of illegal drugs the critical incidents that came to light in the research involved, without exception, relations and friends who were young adults. In the focus group excerpt below Sameena, a South Asian girl who avoided all forms of substance use, highlights a sad event in her family that had had the effect of reinforcing her negative attitude towards drugs.

Sameena: My cousin's brother, he took a lot of drugs and all that. And he had an accident because he got into a fight and he got stabbed. And he went to the hospital but he couldn't be helped because of what the drugs had damaged in his body. Mostly it was his brain that was affected. And he was a really close cousin, and he died. Actually, the whole family got really upset by that. It's the sort of thing that makes you think before doing anything.

Moderator: Has it made you particularly anti all sorts of drugs then?

Sameena: No, I was anti drugs before, but this has made me even stronger. So if anybody else was doing it, I could actually give them an example – 'Look what happened to him.'

school 10, focus group with 2 males, 3 females 4 =White, 2=Asian, 25/10/97

And here Tracey, a self-confessed drinker and smoker, draws attention to the way her determination not to 'do hard drugs' has been influenced by her first hand experiences of the unpleasant impacts of her sister's involvement with hard drugs.

Tracey: My sister, she went through the phase when she tried loads of drugs because she was on the dole and she didn't have anything else to do. She went round to somebody else's house and she continually took drugs, she didn't even know what she was taking half the time and she used to come back and she used to go up to my mum and say 'I really hate you. I don't want to know you, you're always in my private life'. She turned into a monster.

Jim: She all right now?

Tracey: She's all right now, but like she wouldn't do things - she'd hardly have a bath or anything.

Jim: What was she on?

Tracey: She don't know - she had cannabis, she had speed once, she had no end of things, she was like someone different. I used to hate it, she's like come home and she wasn't like my sister anymore, she was someone else.

Moderator: So that's had quite an impact on you?

Tracey: I'd never do that. Cannabis maybe, but nothing else I don't think.

Jim: I'm going to stick to beer.
Tracey: Beer and sex I think.

*school 10, focus group 01, three males, three females, 4 = Whites, 2 = South Asian,
27/10/97*

Judging from her comments Tracey's experiences had sensitised her to the harm potential of one focus of drug education (hard drugs) but had not influenced the development of a favourable disposition to arguments geared towards 'healthy' choices in respect to under age drinking and sexual activity. Her case contributed to the impression that critical incidents have the capacity to increase identification with, and motivation to, take up of specific health education messages but are unlikely to lead to blind acceptance of all the arguments embedded in school-based programmes of health education.

Principled beliefs

An important source of evidence that an individual's 'principled beliefs' have an important bearing on their disposition to health education arguments was data supplied by young people influenced by Islamic teaching. The social and religious experiences of this group meant that they shared a common outlook that drinking and drug use were morally wrong. (Contrasting with some shades of opinion on the issue of whether it was possible to be a good Muslim and a smoker). The focus group discussion from which the following excerpt is taken took place in a school with a high Muslim population. Participants had previously identified religion as a factor implicated in the low rates of smoking in the school (compared to others in the research). Here they are in close agreement that the influence of religion also helps to explain the low rates of drinking in the school.

Fatima: It does.

Imran: For example. I'm a Muslim, I follow Islam and the religion prevents us...

Tahir: Forbids us.

Imran: ... forbids us to drink alcohol so I think that has an effect.

Moderator: So - can you clarify something for me then. In Islamic teaching what is the - if you like - the line on smoking?

Tahir: Basically any toxicant in Islam is forbidden. You can't take drugs - anything that makes you lose your senses - lose control of yourself. Like alcohol, take drugs, all that. You can't take it. You're not in control of yourself.

Imran: Because in the end you won't remember him.

Moderator: I see. And smoking would be classed in that way?

Imran: No, not in that way.

Moderator: I suppose smoking doesn't make you lose your senses.

Harjinder: In a way it is, and in a way it isn't. You're damaging yourself.

Imran: Yes, you're damaging yourself.

Moderator: O.K. So it's perhaps bad in the sense of being toxic, but not so bad in terms that you can lose your senses.

school 01, focus group 02, 4 males, 2 females, all South Asian. 18/1/97

The tendency for Muslim pupils to avoid smoking, drinking and drug use on the grounds that these practices, in particular drinking, are morally 'wrong' triangulates with, and helps to explain, the ethnically patterned response to school-based health education highlighted in Chapter 4. (As does forthcoming findings on the theme of cultural norms). It would be false to give the impression, however, that Muslim pupils were the only ones in the research whose drug-related choices were influenced by their personal 'principles'. Ruth, a member of an evangelical Christian sect, provides another (albeit rare) example of a pupil with a stance on drinking and other forms of substance use based on the belief that these practices were morally wrong. Here she highlights the way in which her bible-influenced beliefs about the 'wisdom' of not drinking and health education messages on the subject are highly congruent and mutually reinforcing.

Ruth: The good thing about Christianity is, you've got your own choice, but it does say in the bible – about it's dangerous to drink. Not because of any health

reasons but because of what you can do or say when you're drunk and you can actually lose respect.

school 08, focus group 02, 6 females, all White. 23/4/97

Ruth's raising of the concept of respect is interesting. Motivation to respect parental wishes and expectations (an external influence) is highlighted and links to other themes discussed below about the influence of family context and cultural norms. There were indications in the evidence, however, that interest in how to achieve and hold on to this personal characteristic united pupils across social divides. For the pupils featured in the extracts and excerpts featured in the remainder of this section it seemed that there was some personal satisfaction to be had on this score by acting in a way that was perceived to accord with the dictates of (highly individualised) conscience or personal values.

Interviewer: (what was) responsible for you saying no to wanting to, to involvement with drugs

Peter: ... parental ...

Ian: Yeah.

Peter: The parents they ...

Ian: Don't really lecture you but....

Peter: No they don't lecture you but ...

Ian: You could imagine what they're going to say.

Peter: Yeah, I mean ...

Ian: It's like mum getting mad.

Peter: And also if you like, you don't take drugs like for them kind of thing because you realise how disappointed they would be if you actually did

Ian: They brought you up so the least you can do is ...

Peter: Yeah.

Ian: It's kind of moral.

Peter: Yeah.

school 2, interview with 2 males, both White, 24/4/98

The same strand of ethical reasoning can be seen to lie behind the determination of the young woman, featured in the quote below, to resist the temptation of joining in with the

recreational activities of her friends.

Bethan: When I hear of all my friends going out I am very jealous of them because I'm the sort of person who would like to go out and get absolutely pissed and go on a massive pub crawl and not get home that night.. I'd love to be able to do that - but the thing is, it's my dad - I have so much respect for my dad - that because he's not happy with that, then I wouldn't go out and do it.

school 8, focus group of 6 females, all White. 23/4/97

Like the majority of the young people in the research Bethan's general approach to her behavioural choices appeared to be flexible, as opposed to dogmatic (based on the application of 'rules' that stayed constant in the face of all subtleties of surrounding circumstance.) She, and her like-minded focus group colleagues, did not seem to see anything wrong with recreational substance use *per se*. They did, however, declare themselves 'against' drink-driving, drug 'pushing' and other sorts of behaviour with obvious negative implications for others. If the perception was that no one else stood to be hurt, the general attitude was summed up by a phrase encountered with great regularity in the research: 'it should be a free choice'.

A final context in which principled beliefs emerged as potentially relevant was resistance to pressure. (Evidence presented later highlights some flaws in the thesis that underpins drug education approaches which remain popular in the UK: namely that substance use by young people is indicative of personal deficit with regard to the skills to say no to drugs.) In the conversation just prior to the extract below the two female smokers had been reflecting on their intentions in relation to illegal drugs. Here Sarah implies that, for classmates involved in these practices, peer influence is an issue.

Sarah: I think if you have principles on things you can stand up for them and nobody is going to try and make you change them. I'd feel alright to do that.

Rachel: Some people, they probably follow the leader a bit more.

Sarah: A few people.

school 09, interview 01, 2 females, both White, 22/04/98

Speaking for herself, she anticipates that her inner principles will enable her to withstand unwanted pressure to accept a drug offer, if made, in the future.

Self-identity

An unmistakable message from the findings was that smokers, drinkers and drug takers (overwhelmingly users of cannabis) gained satisfaction from their practices. An important aspect of this sense of satisfaction, the evidence suggested, concerned self-identity. The comments in the two extracts below relate to personal interest in the projection of a desired self-image to others. The perception they highlight - the positive association between smoking and 'hardness' - was encountered with regularity in the research.

Karen: Yeah it's like when you smoke your first cigarette you think, 'Oh I've done that. I'm hard now'.

school 7, focus group, 3 males, 3 females, all White, 25/11/97

And similarly

Harjinder: Normally Black people are quite hard. So then the Asians try to be hard as well, so they start smoking as well.

Moderator: That's interesting. To copy the Black lads?

Harjinder: To copy the White and Black kids, both.

Moderator: Do you really think that's really happening at the moment?

All: Yeah, Yeah.

school 01, focus group 02, 4 males, 2 females, all South Asian, 13/11/97

The suggestion that smoking-related norms and practices are in the process of changing amongst young generations of South Asians in the area being studied 'fit's' with the gender overlay to ethnicity-linked patterns highlighted in Chapter 4. This is especially the case when the evidence about the strong impact of cultural norms of expected behaviour on South Asian females (see 6.1.4) is taken into account. [For a review of trends in alcohol and tobacco consumption within the population group of 15-16 year old South Asian pupils see Denscombe and Drucquer (2000)] Boys, it seemed, were able to act on their attraction to smoking and its perceived benefits. For (some) girls certain aspects of the Western lifestyle (socialising in mixed groups and participating in leisure activities that might include drinking or smoking) were appealing but judged 'impossible' because of circumstance.

Other perceived advantages of substance use in relation to self-identity seemed to have more to do with the ability of smoking, drinking and/or drug use to signal something to self (as opposed to others). One aspect of this related to their perceived ability to provide 'proof' that one was in control of one's own destiny. Sarah, in the following excerpt illustrates how the need for an emblem of self-empowerment can favour choices which, ironically, may detract rather than add to levels of control in the long run.

Sarah: I only think that, it's our choice in the end, it's no others. You know the risks and everything that goes with it and you know all the details because it's been drummed into you about I don't know how many times. So you know what you're doing.

Moderator: So it's, you're in control of that, of making the dec....

Sarah: It ... it's partly, yeah, our wish. It's being in control. (...) It's like this; smoking – that's your decision. You....that's our decision if we want to smoke, yeah? So that's nobody else's decision.

Moderator: So smoking is actually a way of ...
Sarah: ... to show that we're in control

school 5, focus group 02, 2 males, 2 females, All White, 16/4/97

Another capacity in which substance use was perceived to be helpful was self-affirmation. This was particularly the case for young people motivated by a desire to challenge themselves through risk-taking and/or distance themselves from the mainstream 'humdrum' of life. The comments below illustrate this point and strengthen the evidence for a previous argument. Namely, that the conclusions of the cost-benefit analyses behind some young people's 'unhealthy' substance-related choices, reflect the attachment of low value to personal safety/ long life span.

Moderator: Do you think that the dangers are real?

Dylan: I think they are real, it's just that I don't want to one day wake up and think 'Oh, I could have done that' - I just want to live life to the full, and if it means taking some calculated risks then so be it.

Moderator: What do you see as a 'calculated risk'?

Dylan: Basically, it's the good stuff against the bad stuff. The good stuff is you could possibly have an amazing time - you know, I haven't actually taken one, but I know a lot of people that have. I've read Irvine Walsh, 'Ecstasy', it says all about Ecstasy. You can have an amazing time and just feel great. The bad stuff is you can die. So, it's which one you think is more important to you.

Collette: It's like taking acid. You can have a good time, you can have a bad time and you can die. Which ever way it turns out for you, you just have to say - do I want to take this risk. There's the possibility that I am going to have an amazing time.

Kimberley: I would never take that risk.

Adam: Yet, but like I'd say to Dylan. I'd say - if you excuse the phrase, I like living life to the max, but anything that's going to mess up my body, or it is going to enable me not to do something in the future because of taking one risk and I'm not going to be able to get on with other things.

Kimberley: I like to live, like, to the max but I wouldn't take stupid risks like drugs or anything. It's just stupid.

Adam: You might feel good for about ten minutes, and then you're going to get a massive downer.

Kimberley: Like - you might as well be 10 minutes later in this world, than 10 minutes earlier in the next, mightn't you.

Moderator: It's interesting, the discussion that is opening up - so in this group, there are different ways that you are looking at the balance between potentially good and potentially bad things.

Collette: I don't take E and stuff, but I would probably take more risks, I would do things differently to have a full life. I mean - I wouldn't do it, but then, if it was safe, then I would - even if there was the possibility that I would have a bad time - you know, even if it was illegal.

school 05, focus group 01, 2males, 2 females, all White, 16/4/97

Expressions of interest in a 'full life' and a 'live life to the max' orientation were encountered on a regular basis in the research and often linked to the view that 'if you can't take a few risks when you're our age when can you?' The influence of such ideas almost certainly has relevance for the limited uptake of health education arguments, as highlighted by the quantitative evidence presented in Chapter 4. These comments also highlight the importance of the critical life juncture that the young people in the research had arrived at. On a subjective level, the evidence suggested, emotional needs linked to self-identity were a powerful driver of the young people's behaviour. On a more objective-level new social and environmental 'threats' and opportunities were opening up because, for most of them, their age meant they had increased levels of independence, an improved financial status and were in a better position to circumvent legal prohibitions to substance use. This intertwining of self and context, which has already been highlighted at various junctures in the discussion, was a feature of the data as a whole. In the data presented above the emphasis was on personal factors such as beliefs, attitudes and emotional needs. In the themes discussed below the emphasis is on the way that young people's subjective dispositions to health education arguments are influenced by the social conditions of their lives.

The demands of social and school life

The evidence certainly highlighted perceptions about the benefit's of substance use in the self-identity and self-development context. It also demonstrated the extent to which the pupils in the research valued the effects of mood-altering substances as a way of coping with the 'demands' imposed by the conditions of their social and school lives. This is not to say that the pupils in the research failed to recognise the sheer pleasure-value associated with the consumption of tobacco, alcohol and/or cannabis. It is to suggest that in addition to the desire to escape boredom or to experience a 'buzz' (both often put forward as reasons for substance use) there were other motives implicated in pupils' 'negative' reactions to health education messages. The following extract supports the analysis that the need to relate well to others in social situations was an important reason why the mood-altering properties of substance use were perceived to be so valuable in the context of leisure.

Moderator: So would you say that all of you drink alcohol.

All nod in agreement

Moderator: So what is it that you like about the effects of alcohol?

Steven: Everyday things, like bumping your arm, become really funny.

Carolyn: You can have a great laugh with your friends.

Myles: You become more confident. You can just go up and talk to total strangers.

Helen: It's helped me meet new friends, just by going up to people and talking to them in the pub.

Steven: It can help you get off with girls.

school 4, focus group 01, 3 males, 3 females, all White, 5/2/98

In the previous extract the dis-inhibiting effects of alcohol, undoubtedly the most popular

substance in the research, receive appreciation. Below Debbie highlights how in her experience, the combined effects of smoking and drinking act to enhance her enjoyment of social interaction. Her comments also serve to put the 'failings' of school-based health education into realistic perspective. If such a personal 'lesson' of the risks associated with smoking failed to influence Debbie's smoking behaviour in relation to smoking the prospects of formal lessons about these risks encouraging 'healthy' choice on her part are likely to be slight.

Debbie: I smoke, and my granddad had eight heart attacks off. And that should really teach me a lesson, but it's something I enjoy –it's sociable it goes well with a pint and I enjoy it. I like it.

school 08, focus groups 01, six females, all white, 23/4/97

It may be controversial to assert that the leisure and 'work' contexts of 15-16 year olds are associated with levels of stress that help to account for their generally unfavourable pre-dispositions to health education arguments. However, from the data it was hard to escape the impression that school-life is a source of stress for many young people in this age group: one that set up a need for a means of relaxing and/or releasing pressure.

The following extract highlights the perceived value of smoking as a form of stress relief. The positive effects that Collette, a regular smoker, experienced as so useful are almost certainly linked to the dependence-inducing properties of nicotine (a feeling of being on edge as blood levels fall). This does not alter the fact, however, that her subjective experience was that smoking helped to restore her to good mood and combat stress.

Collette: There is nothing nicer than after you've had a really stressed out day, when you've had the first three lessons and you've been shouted at in all three of them, and you have a nice fag and you just go 'wow !' (*Body language indicating unwinding/ achievement of relaxation*).

school 05, focus group 01, 2 males, 2 females, all White, 16/4/97

The concept of stress relief was not only relevant in the case of smokers. Many drinkers highlighted the benefit's of a 'good night out' – one which involved going out with friends to venues where, typically, alcohol would be consumed – in the context of their strategy for keeping 'sane' in their GCSE year. The sorts of sentiments expressed here were repeated many times within the focus groups and indicated that pupils at this crucial juncture in their smoking have been highly exposed to (and accepting of) messages about the need to strike a healthy balance between work and play.

Bethan: I think you need to strike a balance really and have a social life. Like they say, if you study too hard and you don't go out - you'll end up turning round and saying 'I don't want to study full stop.

school 8, focus group 01, 6 females, all White, 23/4/97

The final excerpts are chosen because they provide a striking illustration of how one young woman's substance-related attitudes and choices reflect her belief that she *needs* to go out and having fun if she is to survive the stresses associated with doing GCSEs.

Tracey: Well I respect your views but I'm just saying that, what with me being so near to death once in my life, it's made me think that you've got to get out there and have as good a time as you can. I'm enjoying myself now. Before I wasn't and now I'm having a wicked time.

Debbie: I mean, tomorrow you could get run over by a school bus.

Tracey: I just think you should go out and do what you want, and get drunk if you want.

Moderator: Could you tell us a bit more about the incident you just mentioned to us?

Tracey: Sure, yeah. Well, everybody knows about it. I took an overdose of 25 paracetamol just before Christmas. And I got to hospital and the doctor said that he couldn't pump my stomach because I was too far gone and if I'd got in there three quarters of an hour later I would have died. And they still weren't sure if they could save me or not – but they did. Yeah, it was pretty bad.

Moderator: Has being in such danger altered your perspectives on life?

Tracey: It has a lot.

Interviewer: Could you describe that a bit.

Tracey: It made me more easy going. Like, before I was like 'Oh no, I can't go into pubs.' And now I go out and have a laugh with my mates and stuff because I think you should enjoy life more if you have got it

Debbie: Live for the day.

Tracey: Yeah, I agree with you totally. Now I'm really easy going.

And later in the same focus group discussion

Tracey: Just before my overdose, one thing that contributed to me taking it was the school. I mean I had teachers all running round me, going 'you've got your mocks, you've got your mocks if you don't get good grades you won't go to college' and I just sat there thinking 'I won't get into college, I won't get into college' and I just got really stressed really easily and that was one of the reasons, because of all the stress of exams and stuff.

Sharon: You've got to do some work - because it's your future - but also you've got to get out and have a good time

school 8, focus group 01, 6 females, all White, 23/4/97

It needs to be pointed out that this was the only occasion in the research when such an extreme reaction to stress was encountered. Tracey was far from alone, however, in giving the impression that the demands imposed by GCSEs had the potential to outstrip personal abilities to cope with them in a 'healthy' fashion.

Family context and influence of friendship groups

The role of parents in influencing the development of personal beliefs and attitudes congruent with health education messages has already been highlighted. The following

excerpt is useful because it links back to the theme of principled beliefs and also serves to highlight an issue about the importance of the interaction that take place between young people and their parents on the subject of drugs. Sarah's comments were triggered when asked about the influence that her parents had had on her 'healthy' choices.

Sarah: That's a difficult one. I think giving some sort of restrictions, like about the time that you get in. Sometimes I get hassled about it, but then they sit down and try and explain it and you can sort of see what they are getting at.

Rachel: In the end you've got to have your own restrictions that come from inside of you, but to begin with it helps to have them laid down for you.

school 9, interview 01, 2 girls, both White, 22/4/98

The communication, in Sarah's instance, appeared to be characterised by mutual respect (her parents took time to explain the reasons for their ground-rules). In other instances, judging from comments, the success of the communication was undermined because it was perceived to be unreasonable and/or because parents' credibility in the eyes of their sons and daughters was low. The following extract illustrates this point. It also suggests that lack of effective reinforcement for health education messages in the home and helps to explain the limited success of the intervention.

John: My Mum found a fag in my bedside table, and she had a go at me, but like she's been smoking for twenty-five years.

Moderator: What do you think about parents who do smoke telling youngsters not to smoke? How does it come over?

Joe: It's hypocritical.

Marie: My mum has been smoking for about twenty years, and her Mum don't know yet.

Moderator: Your mum's mum doesn't know? Really?

Marie: No. My nana don't know. She has to hide everything if she comes round.

school 7, focus group 01, 3 males, 3 females, all White, 25/11/97

Other evidence strengthened the impression that parents whose practices ran counter to health recommendations were perceived to be in a poor position to provide credible advice (or lay down ‘laws’) on smoking or drinking.

Parents were not the only source of external influence to emerge as important. There was also a great deal of evidence suggesting that the attitudes and practices of influential friends had a bearing on a young person’s motivation to receive health education arguments. There were strong indications that pupils in the research were familiar with the view that substance use denotes an underlying inability to resist pressure from peers. Indeed, the term was frequently introduced into discussion spontaneously.

Kiran: Ask him why he started smoking (points to Shiraz)

Moderator: Only if he wants to tell me

Kiran: It’s because of his mates innit

Shiraz: I was in the park with my older brothers and...

Kiran: ...they think they’re hard don’t they....

Shiraz: ..and they gave me one. After all these years, yeh. And I find out what I have been missing. And then they make me pay for it

Kiran: It’s peer pressure

school 01, focus group 01, all South Asian, 3 males, 2 females 13/11/97

To say that the young people in the research were aware of the crude peer pressure thesis is not to say that they accepted it. In particular there was a tendency for pupils to take issue with the idea that young people are ‘victims’ of *unwanted* pressure to conform to group norms. One way pupils did this was by highlighting the variety of peer groups they chose to move in and out of, depending on what Chloe, in the fragment of discussion below, refers to as ‘priorities’.

Chloe: I tend to float from group to group. I mean, I don't ... you know, like say "I don't like you any more. I'm going..." (laughter). It's a case of ..(pause)
Interviewer: feeling comfortable with a different group of people.
Chloe: Yeh. I mean I don't necessarily like being stuck in... not stuck...being in one type of group. I think to an extent the group we're in isn't like that. You know, we all have different priorities.
Charlotte: We've all been friends for years so we know what we're about and we don't put each other down because we all like different things.
Chloe: It's not like, you know, you have to stay with me because you're my friend, you know?
Charlotte: You don't have to. You can go with someone else if you want to.
Chloe: It's your choice.

school 07, interview 01, 2 females, both White, non-smokers, 24/04/98

Another counter-argument put forward was that *real* friends would not try to exert any pressure on a person to do something they did not want to do.

Ian: But the type of people who'd pressure me into doing it (smoking) wouldn't be my real friends anyway. It's the kind of people you hang around with. 'Cos I could pressure him (*Peter*) but he'd just go "No". And he can pressure me and I'd say "No". Erm, yeh I think it's all to do with friends.
Interviewer: But what if the group that you went out with or all the people at (the sports club) were smoking?
Ian: A lot of them do in fact.
Interviewer: You don't feel any pressure there?
Ian: No. if anything I'm kind of proud that I don't. Therefore I'm an individual and I want to keep that.

school 07, interview 02, 2 males, both White, 24/04/98

Ian's final remarks chime with the previous finding about the way that, for some pupils, sticking to 'good' intentions in the face of temptation could bolster a sense of self-respect. The comments below represent another challenge to the peer pressure thesis – specifically, it's un-discriminating application to all age groups. Here Nicola argues that, by age 15-16 years, susceptibility to peer pressure is largely outgrown

Julie: Well, I had my first cigarette in the first year because, I can remember everybody used to go to the bottom of the field, near the trees, because that's where the teacher wouldn't catch you. An' that's where I had my first smoke.

Interviewer: And when you had that experience, did you have any pressure?

Julie: Yes.

Interviewer: How strong was it? Were they getting you to do something that you didn't want to do?

Julie: It was more that they offered me smoking and I felt that I had to take it. If not they would be offended.

Interviewer: What would it have been like if you had said 'No'? Would you have had a hard time?

Julie: I don't know. My friends aren't like that, but when you're that age you think – 'Oh no, they'll fall out with me. I don't want them to fall out with me'.

Nicola: I think especially in the 7th and 8th year, you want to be like everyone else – you don't want to seem pathetic for not doing so. So I think that's it. Also, I think when you get older it's not such a big thing that you're not supposed to do. You've got more freedom, so you don't think that you have to do things you're not supposed to do just to seem good.

school 12, interview 01, 2 females, both White, 22/04/98

It was not just in the context of discussion of smoking that young people took opportunities to challenge the peer pressure thesis. Drinkers and cannabis users were also quick to point out that their behaviour was under their own volition. The two pupils featured in the extract below attended a deprived, inner city school that was under special measures at the time of the research.

Cath: Most people are in control of their own actions these days. If you don't want to, you just say "No". It's like when I'm sitting round my mates house and they're all smoking cannabis. If I don't want no more, then they'll just say "Do you want any more?" and I'll go "No", and they'll go, "Go on, just one more drag" and go "No", and then they just stop.

John: It's all right round my way, just say "No" and that's it.

Cath: You just say, just say "No" and they go "Yeah, alright then".

School 10, focus group 02, 2 males, 3 females, 4 White, 1 South Asian, 10/11/97

The following extract contains a similar theme expressed by pupils attending an

academically successful school sited in an affluent market town.

Tracey: I was never forced into smoking cannabis at all. It was purely my choice.

Sharon: You just get offered, and you either say you want to try it, or you don't.

Tracey: I want to try it. All my mates smoked it and I wanted to see what it was like. So they said "Do you want some?" and I accepted. You've got to experience something before you can preach about it.

Moderator: So you wanted to experiment? I suppose what we're beginning to think about here is peer pressure.

Debbie: I'm not affected by what other people do. I do whatever I want to do. What everybody else does doesn't bother me.

Sharon: What I like is you can make your mind up, and you're going to be picky on your friends also – who are you going to be with, it depends what group you get in with, because if you're in a group and they do smoke, often it leads to other things, but if you're in a group where they don't smoke...

Ruth: But the people you hang out with, they should respect you for your opinions and what you want. If you've got proper friends, like proper people, mature enough, they won't say 'Oh you should have this' – they listen to what you want, they just care. ...

Debbie: (*interrupts*) No, I don't sit in judgement because that's what they do. I just take it for granted. If that's what they want to do, that's up to them. It's none of your business – you shouldn't try and affect the way people think. You can have an opinion on it, and you can voice your opinion, so long as you respect people, that's O.K.

school 08, focus group 01, 6 females, All White 23/04/97

Agreement that there were flaws in the crude analysis that young people were pressurised into substance use by friends cut across class, gender and ethnic boundaries. The evidence from the focus groups supports the conclusion, however, that the linked processes of peer alignment and subtle peer influence have strong relevance in the drug education context. In the presentation of findings below the wider social processes tied up in the transmission and development of culture come to the fore.

Cultural norms

The main source of evidence for the finding that cultural norms had an effect on receptivity to health education messages were comments from South Asian pupils about the dire consequences that would follow if they made moves to adopt a lifestyle of which their parents disapproved. The accounts that provided the most illuminating insights into the impact of cultural context on personal choices were those of the young South Asians who smoke and drank and anticipated that their parents would be mortified if it this came to light. In the majority of cases girls were the source of relevant comments. However, the excerpt below is featured to offset any impression that traditional norms of expectation and behaviour had no relevance for the boys in the study.

Moderator: Can I ask you, among Asian lads, would you say quite a lot of them smoke?

Kiran: Yeah. The thing with Asians is, there's guys I know, there like about 18/19 and they still don't smoke in front of their parents, so their parents don't know. Because if they do smoke in front of their parents, they'll get kicked out of the house - it's like disrespect to the family.

Brian: Is that what it is? Yeah, Yeah.

Kiran: Like, if I was to get caught smoking. I wouldn't be here.

Moderator: Your parents don't know you smoke?

Kiran: Nah. I've got a few friends who smoke, they got in trouble a lot and their parents just kicked them out of the house.

Brian: What because they smoke?

Kiran: Smoke, drink, caught by the police - stuff like that, minor offences, but their parents kick them out.

Brian: Like no matter what age.

Kiran: Well, they were about 18.

school 10, focus group with 2 males, 3 females 4 =White, 2=Asian, 25/10/97

In this account two Hindu females in the same, multi-cultural school highlight the serious risk that they know they are running by transgressing traditional cultural norms that cast

substance use as totally unacceptable for Asian girls. The context for the comments is these pupils' rejection of the possibility that it's association with a glamorous image was part of their motivation for smoking.

Interviewer: OK, so it's more that smoking is just something that you basically enjoy. What about your mums and dads, do they know you smoke?

Both: No.

Chetna: They would kill us. They would. Asian parents yeah, they're like – 'Girls - it's not good. It's not good if a girl smokes'. It's alright if a boy smokes but not a girl. That's how it is.

Interviewer: Right. So a lot of the Asian boys are doing it?

Rajwant: Yeah, yeah.

Chetna: Yeah. My brother smokes and my dad says that's alright because he's a boy.

Rajwant: But if they found out...

Chetna: They'd batter you.

Interviewer: Really?

Rajwant: Yeah.

Interviewer: So there are different standards for boys and girls and that's still the case?

Both: Yeah

Interviewer: OK. Have you got any older sisters or who have been found out ? I'm interested in the sort of consequences ...

Chetna: What are consequences?

Interviewer: The sort of row they might get in to with their parents ...

Chetna: Chuck em out the house.

Rajwant: Chuck em out the house yeah.

Interviewer: Really, as serious as that?

Both: Yeah.

Chetna: They'd chuck em out the house.

Interviewer: So you are taking a big risk [smoking]

Both: Yeah (*vigorous nods*)

school 10, interview 02, 2 females, both South Asian, 5/5/98

Other comments by South Asian pupils throw light on the deeper reasons why 'improper' behaviour was seen in such a very serious light by 'strict' or 'old fashioned' Asian parents. One issue was that it was understood to reflect badly on their personal standing in the community. Another closely linked issue, was that a 'bad reputation' could ruin the

prospects of daughters securing a good marriage. Although these considerations are out of the general spirit of the times it was interesting to find that none of the South Asian girls in the research took the opportunity to rail against the 'unfairness' of the high standards of behaviour expected of them. On the contrary, pupils of both sexes were inclined to attribute their parents' motives in 'laying down the law' on substance use to their desire to ensure their children had better opportunities in life than those they had encountered.

Norms have a dynamic quality and, from the research, it was possible to see that recent social developments with regard to the social acceptability of recreational drug use create difficulties for preventative work in schools. A number of South Asian pupils suggested that their personal decisions to use substances reflected a shift towards more permissive attitudes towards drugs amongst second and third generation Asian Britains. White pupils, too, suggested that responses to drug education messages were affected by cultural factors and fashions. Identification with 'townie' sub-culture, it was suggested, offered an explanation for resistance to alcohol education because 'pub-ing and clubbing' was an integral part of this lifestyle. Similarly, identification with laid-back 'skateboard' culture meant that messages designed to emphasise the risks of cannabis were unlikely to have the desired impact on attitudes or behaviour.

The growing social acceptability of drugs that these findings point to needs to be understood in the broader context of the growing availability and affordability of drugs to young people. Evidence in the following section specifically relates to 'concrete' obstacle

to the success of drug prevention efforts aimed at young people.

Drug availability

The argument that both legal and illegal drugs were relatively easy to get hold of, if wanted, was encountered time and time again in the research. Here Cath is talking about the latter. It seems that her school had been successful in clamping down on dealing at the school-gates but has been unable to stop the supply of drugs to young people in the 'know'.

Cath: I'll just like have about five drags on a spliff - depends how many are going round.

Moderator: Is that in pubs or in what sort of social situation would that be probably?

Cath: We go to the park. The lads play football while we just sit on the side. Then two lads will come over and we'll sit there and have it with them.

Moderator: So is it quite available would you say then

John: Yeah.

Cath: Mm.

Rob: It depends on the area where you live really.

Moderator: But you think for most young people, where ever they lived if they wanted to get hold of it, it would be available? Or not?

John: It's easy. In some areas.

Cath: There's always people down there dealing or like er, a boy ok, that I know does.

Moderator: Do you get people round the school gates, that sort of thing or is it actually students here?

Cath: There was a few years ago, a student, but there ain't, you don't get them round the school no more and you don't get them in the school. You go to their houses and that now.

school 10, focus group 02, 2 males, 3 females, 4 white, 1 South Asian, 10/11/97

Judging from the evidence, a ready supply of drugs to young people who wish to use them

was not a characteristic limited to deprived communities. The two pupils whose comments are featured below came from a socially mixed school in an affluent commuter village. They highlight the interesting issue of the extent to which different drugs have become a taken-for-granted aspect of pub and club culture.

Sarah: Well there is a lot around. Partly I think it's to do with the social scene that you are in. For people who go clubbing there's things like whizzers.

Interviewer: Ecstasy?

Sarah: No I wouldn't say that so much, Milder things

Rachel: Drugs to keep them dancing.

Sarah: Yes and to get them a bit high without having to buy drinks because they're so expensive in clubs.

Rachel: Where we go though, pubs that put on bands, it would be cannabis. It's more relaxed and laid back.

Sarah: Yes some people smoke cannabis, but personally, I don't

School 9, interview 01, 2 females, both White, 22/4/97

In addition to evidence suggesting that young people's attitudes have been shaped by the penetration of illegal drugs into the social world they inhabit, there was plentiful evidence that ready access to alcohol was interfering with willingness to take health education messages on under-age drinking seriously. Poor enforcement of legal barriers to sale appeared to be a contributory factor to the perception that alcohol was 'easy' to get hold of. The procurement strategies outlined by the young people were varied and imaginative with older-looking girls faring particularly well in terms of getting access to alcohol in pubs and clubs. For those too young looking (or too poor) to socialise in such places parties at friend's houses or consumption in parks or fields were alternative options. The following extract gives a flavour of the ingenuity displayed in the context of bids to flout the law on alcohol.

Claire: There's a lot of people who are just in it for the money, and they'd serve anybody.
John: They make you take your own bag, so you haven't got theirs if you get caught.
Richard: There's quite a lot of shops that will serve people.
Joe: But you have to have a bag with you or else they won't serve you.
Richard: Or you have to be able to hide it in your coat or something.
Moderator: So basically, young people are going to fairly soon get an idea about the places that serve them and the places that won't.
Richard: Most of them try quite a few, but yeah - they find out.

school 07, focus group 01, 3 males, 3 females, all White, 25/11/97

One of the key *raison d'être*s of the 'new public health' (Ashton and Seymour, 1988) of which school-based health education is a part, is to combat anti-health forces. Reducing the demand that fuels the profits of retailers prepared to exploit the attraction of legal minors to illicit drinking could contribute to this goal. However, the probability that school-based drug education programmes will attain this goal (as well as narrower smoking, alcohol and drug-linked strategic goals) is compromised by the 'mismatch' between audience wants and preferences and the nature of the programmes themselves.

5.2 Pupils' views about programme shortcomings

The conceptual schema (see Chapter 2, page 78) proposed that delivery practices (as shaped and determined by the organisational blueprint) would affect the nature of drug-related interaction at the pupil-teacher interface. The evidence presented in this section provides some confirmation that this is the case. It also provides understanding about specific aspects of delivery that affect pupils' willingness to engage as hoped and intended

with the process. The findings cluster around four areas of shortcoming and derive from critical comments received. Such comments greatly outweighed positive ones, a phenomenon that might be partly attributable to one of the devices used to initiate discussion about experiences of and reactions to drug education in school. Pupils were presented with a table of findings about the proportions of previous Year 11s in their school who had answered the survey question about the impact of health education on their personal willingness to take risks with their personal health in the positive and negative. Although presented in a 'deadpan' way these triggers tended to be interpreted by pupils in terms of 'proof of failure' and encouraged speculation about why this was the case. Another possibility needs to be entertained: namely, that pupils had experienced lessons that responded to their wants and preferences well, but were unable to *recall* the experience.

The curriculum context

Regardless of whether pupils were in schools where health education was part of tutor-time, time-tabled PSE or delivered in a 'stand alone' curriculum slot, there was a unanimous view that the subject did not have an equivalent status to the 'proper' (academic) subjects on their timetable. From the data it was possible to see that the impact of this perception was sometimes damaging, in terms of personal motivation to enter into the spirit of proceedings. This extract illustrates this point.

<i>Tom:</i>	The thing is, health education's not taken seriously.
<i>John:</i>	Lots of people muck about and spoil it.
<i>Tom:</i>	Mr Barrett. He's too light hearted and flip.

Claire: I don't mind him. At least he makes it understandable.

school 07, focus group 01, 3 males, 3 females, all White, 25/1/97

These comments were not the only ones to suggest that classroom discipline might be a problem in health education lessons and this highlights an interesting issue. The active/participatory methods known to be a hallmark of good practice in drug education require a classroom climate conducive to their use. This is hard to create when people are 'mucking about' because they see no point in the subject – but without it the relevance and value of such methods is seriously compromised. The negative light in which health education lessons tended to be seen by the pupils in the research is illustrated again here.

Kiran: Not many people care about health education in schools. If they have some papers to take home they just throw them in the bin and that.

Moderator: Do they?

Shiraz: They don't give a damn. They think it's not actually education.

Moderator: Why is that? Is it because you don't take an exam in it?

Shiraz: Probably.

Kiran: Yeah

school 01, focus group 01, 3 males, 3 females, all South Asian, 13/11/97

In an educational era when cognitive learning, testing and formal exams is the norm for pupils, it is easy to see why so many of the pupils in the research perceived that health education was not a serious subject. It's non-examined nature may be a contributory factor although this never came up spontaneously in discussion. Judging from the evidence, the perception that the delivery of health education was in the hands of teachers who were uninterested or ill equipped for the job seemed to be a more pertinent reason. [Evidence relating to the perceived shortcomings of delivery teachers is presented later.]

A key principle of good practice in drug education is that it should start early and receive continuous reinforcement as children develop, building systematically on the knowledge about drugs they acquire (see Appendix 1 and Appendix 2). In practice this requires decisions about *when* in the school career relevant 'content' should be scheduled for best effect. Judging from the evidence programme planners frequently got this 'wrong' (in the sense of it not being synchronised with felt pupil need). The extract below features pupils who attended a school in which health education only appeared in the curriculum of the lower school. Judging from their comments the 'disappearance' of health education as they entered Key Stage 4 was a point of regret.

Bethan: It's really weird - like year 7, 8 and 9, we always went through topics like drugs. We did sex education and all that lot. Now we've got into year 10 and year 11 - in our PSE topics, we don't do stuff like that anymore.
Sharon: Now it's all exam work.

school 8, focus group 01, six females, all White, 24/ 4/ 97

Later on in the discussion the extent to which this mattered to one pupil in the group is revealed

Moderator: I'm interested in how you got your knowledge about the different substances, so that you could make your decisions on the relative risks.
Tracey: Well, when I was going out with this bloke who started being a drug dealer, ecstasy and stuff, I thought 'this is dodgy', and he was trying to get me to take it - so I went to a library and got loads of leaflets, because I didn't know anything about drugs then, to know what he was dealing with, and that's what put me off - really badly off chemicals, because I know what they can do to you and I just wouldn't do them, because I've read them all up.
Moderator: So you found it out on your own initiative?
Tracey: Yes because he was on it and I wanted to see what it was doing to him as well.
Moderator: What about health education at school?
Rebecca: We had quite a bit in year 7 to year 9.
Bethan: We talked about cigarettes and stuff.

Sharon: I think they're leaving it up to us now.
Tracey: In year 7, 8 and 9, you don't really care about that stuff.

school 8, focus group 01, six females, all White, 24/ 4/ 97

The last point is an important one. Tracey implies that information presented when risks were theoretical (because access to illegal drugs was not an issue) was not meaningful and tended to 'pass over the head' of the audience. This reinforces the principle that teaching about drugs should take place within a programme of health education that spans all four stages of children's primary and secondary education. It also endorses the policy view that 15-16 year olds without access to health education on drugs within their school curriculum are denied an important part of their educational entitlement.

The final curriculum-related matter, highlighted as problematical, concerned the allocation of time to health education as a subject. This emerged in relation to criticisms about the depth to which subjects were explored. The following brief comment concerns the illegal drug aspect of the drug education programme of the speaker's school and gives a good flavour of sentiments encountered.

David: It's ridiculous. They try to cram everything (about drugs) into one lesson. You need at least two.

school 04, focus group 01, 3 males, 3 females, all White, 5/2/ 98

Like many of his peers David considered himself knowledgeable about the drugs – more

so than his teachers in many respects – and felt frustrated that complex issues were being reduced to a message about the negative impact of illegal drugs on health.

The message

The relative contribution of message and source factors to the many negative impressions school-based health education encountered in the research was impossible to establish. The two following excerpts, for example, highlight a common perception about the ‘input’ – namely it’s patronising nature. The second, in particular, could have just as easily been used to illustrate points about the off-putting impact of teachers perceived to be moralising or over-directive on pupils’ responses to their experiences at the chalk face.

Moderator: So the majority of you in this group are smokers. Can I ask you about the health education you have had on the subject?

Ross: It seems like when the school tells you stuff it’s just treating you like kids.

Steve: Yea, like kids.

Gary: Secondary sex education. Huh! (*body language conveying contempt*)

school 04, focus group 01, 3 males, 3 females, all White, 5/2/ 98

Similar ideas are expressed here .

Debbie: Like how it’s taught it doesn’t really relate to you. It’s this big thing over there that they assume none of us has ever had contact with.

Tracey: They talk around the topic really.

Bethan: We don’t get in there. It’s like with sex education and stuff – you know that they are afraid to come out and say it. Instead - Mrs Jones-she says ‘You should do this and you shouldn’t do that’. You just sit there and feel patronised.

school 8, focus group 01, six females, all White, 24/ 4/ 97

These comments suggest a wide gap between the realities of practice and the good practice principle of building on young people's existing knowledge about drugs. They also highlight a perception about the judgmental nature of school-based drug education that many pupils shared. The perceived inability of teachers to suspend personal value-judgements when issues were being discussed appeared to be bound up in this impression. The excerpt below highlights a tendency for pupils to prefer inputs giving a 'balanced' view of the positives and negatives of drug use over inputs purely based on messages about the risks and negative consequences of drug use.

Moderator: So is it (illegal drugs) something you've talked about in school, been given some information on?

Steve: The school don't know anything really, I think

Gary: (interrupting) They give you a one-sided view. Don't take drugs – that's it. Don't take drugs. They don't say what they do do for you.

Steve: The only person who gave us both sides was this woman who came in, her son had died from solvents ...

Gary: Yeah, I remember that.

Steve: she came in and she was upset. She told us exactly what it does for you, exactly how it can harm you. She told us every single side of it. Not just, 'oh my son died don't do it'. It was 'my son died and he did it for this reason'. That was like the best speech I've ever had.

school 2, focus group 01, 5 males, 2 females, all White, 4/12/97

The dislike of one-sided messages highlighted here by Gary was widely shared, particularly by pupils who were suspicious of the motives behind the school's attempts to provide them with lessons on drugs. In some schools the young people were of the opinion, when probed, that schools were in the business of trying to support young people to come to their *own*, informed decisions about smoking, drinking and drug use.

Moderator: So I'm sensing that from what you've been saying you're aware of health risks. Your health education lessons have spelt out the dangers of various things, you know for example that drinking might not be too good for you. But from your point of view you are making a conscious decision. If you go drinking then that's a matter of choice?

(General nods and murmurs of agreement)

Moderator: Do you think then, that the way health education is handled respects your rights to make these decisions?

Lucy: Well it's not stopping you from doing anything, it's just telling you what can happen. By having health education they're not stopping you from drinking, or eating chocolate, smoking or anything like that. In your head you know what's going to happen – that's what they told you – but it's still your choice.

Moderator: Do you think the teachers then, when they do health education with you, are trying to help you make your own informed choices.

(General murmurs of agreement)

Greg: Yeah.

school 09, focus group 01, 4 males, 3 females, 6 = White, 1 = South Asian, 19/3/97

More often there was a sense that some manipulation of the facts was going on in an attempt to ensure that young people made the 'right' choices (as viewed through a filter of values which the young people themselves did not necessarily share). The main source of evidence for this came in excerpts of discussion when focus group members aired their beliefs about the arbitrary nature of the distinction drawn between legal and illegal substances. The fieldwork took place at a time when debate was underway in the media and elsewhere regarding the possible reclassification of cannabis and this may have contributed to the frequency with which arguments highlighting the benefit's of cannabis were put forward. These involved it's perceived benefit's in some contexts (medicinal, relaxation) and it's good safety record when compared with tobacco and alcohol. The following excerpt provides a good flavour of the comments received on this theme.

Debbie: It has benefit's for people as well, it's not a particularly dangerous drug, apart from the smoking aspect. You can't die from taking it. It can stop pain,

it can help for medical reasons and it's really so common anyway that it's stupid having it illegal.

Tracey: it's not like smoking. You don't get addicted. You just don't smoke that much

school 8, focus group 01, six girls, all White, 24/4/97

Negative reactions to health education messages that bracket 'soft' and 'hard' drugs together as equally dangerous and risky also appeared to be fuelled by their realisation that the levels of cannabis smoking typical of their age group were quite compatible with normal social functioning. The comments below highlight a film that had clearly had quite an impact on a proportion of the young people in the research who had seen it. Although 'Trainspotting' was based on a work of fiction (Walsh, 1993) it was argued in some section of the media at the time of its release that it glamorised drugs and would encourage young people to try them. Judging from the tenor of remarks in the research its effects were only 'subversive' to the extent that they confirmed young people's impressions that different types of drug and drug taking carry different risks.

Moderator: So when you do drugs at school, do they make a distinction between soft and hard drugs ...

Ross: Same.

Gary: It's all hard to them.

Steve: It's all going to kill you.

Gary: And you're all going to end up in jail robbing old women.

Ross: Like 'Trainspotting'.

school 2, focus group 01, 5 males, 2 females, all White, 4/12/97

Whilst young people in the research tended to be wary of broad-brush messages about the harmful consequences of illegal drug taking there was evidence that the vast majority

found arguments about the unacceptable danger of taking Class A drugs (heroin and cocaine) convincing. The perception that 'drug addicts' were 'losers' appeared to unite many in the research and have an off-putting effect. Distaste for the way in which, with heroin in particular, you had to 'whack things round your arms and inject it' was another factor that appeared to be implicated in the widely shared view that hard drugs should be avoided in all circumstances. The finding that there was a tendency for pupils to equate hard drugs with drugs taken via the intravenous route is interesting given recent evidence about the prevalence of, and rising trends in, the use and misuse of cocaine – a drug that can be smoked in its crack formulation. [See tracking of progress of the anti-drugs strategy in latest edition of the British Crime Survey (Ramsey et al, 2001) and coroners statistics on drug-related deaths (European Centre for Addiction Studies, 2002)]. The implication of this is that school-based programmes of drug education should be endeavouring to effectively challenge any misconceptions that exist about the relative safety of drugs based on mode of administration.

Messages that highlight the danger of illegal drugs that are smoked or taken by mouth could serve this purpose but, judging from the evidence, their effectiveness was often compromised by the 'packaging' employed to get the arguments over. The main evidence for this was comments that highlighted varying responses to the appeal to fear. That was present in some drug education materials. In the following focus group excerpt a group of students are positive about a shocking video and a talk from a teacher who had been affected in a very unpleasant way by smoking.

Tahir: We saw this video at school.
Yasmeen: In tutorial wasn't it?
Tahir: This man lost all his limbs, his legs. He couldn't live without smoking, so they used to get this cigarette and put it through his neck.
Javed: There's even this teacher in our school. She was a really hard smoker, and unfortunately she lost...
Prathiba: ...first it was her toe she had to have amputated...
Javed: ...and now it's part of her leg.
Moderator: Here - in this school?
Javed: Yes. She's still working.
Moderator: Does she ever talk to you about smoking?
Fatima: Yes, she came round once.
Javed: I think it's good that someone in this school has actually been affected because at least we learn.

school 01, focus group 02, 4 males, 2 females, all South Asian boys, 18/11/97

In focus groups where White pupils predominated enthusiasm for approaches deliberately designed to produce negative feelings in the audience met with more mixed reactions. Reactions to 'Sorted' (a video highlighting the dangers of ecstasy by using the case study of Leah Betts who died from an overdose of this substance at her 16th birthday party and circulated to schools by the Department for Education in 1995) polarised opinion in an interesting way. Some students said the film had moved them: they had felt very sorry for the parents and the sad loss of life. Others indicated that they had found it 'realistic'. Others were critical on various grounds. One was it's 'failure' to explain exactly what killed Leah (water overdose was a theory suggested). In the context of a degree of policy-level ambivalence about whether the provision of information to support harm-minimisation goals is a legitimate role for school-based programmes of drug education, this is an interesting finding. In the case of dance drugs (a category which includes ecstasy) the impression given was that information useful in the context of avoidance of harm was

missing from lessons where they were discussed. To fill this information vacuum some pupils were clearly turning to alternative 'authorities' – some of which, the following focus group excerpt suggests, were not particularly reliable.

Moderator: Do you get what you need from these (drug education) lessons?

John: You get information if you want it because leaflets are made available

Claire: Most of your knowledge comes from friends. Femme magazine ran a story about girl who'd had an ecstasy overdose.

Moderator: Is the information accurate?

Claire: Sometimes you get different ideas. Afterwards talking about the article at school, some people said she should have drunk alcohol with it. Some people said she should have taken water.

Moderator: Would clear cut information on things like that be helpful?

Richard: Yeah. For people who've decided they're going to do it anyway - so they could keep out of trouble.

school 07, focus group 01, 3 males, 3 females, all White 25/11/97

In the face of criticism about the way that schools handle drug education the moderator sometimes requested suggestions for more effective approaches. The following extract is interesting because it highlights a difference between pupils who accepted the use of shock horror tactics and pupils who felt that appeals to fear have a very limited power to convey a message that conflicts with personal experience.

Moderator: So if you were thinking about how you would do work in schools directed at to young people how would you organise it to have an impact.

Emma: If you like did a booklet on smoking or something you'd put in some things that people are having. My uncle has just been in hospital, he had to half his lung chopped off and given a scrape 'cos of all the tar built up on it. If they put things like that - what people have to have done in it. Experiences.

John: You could get some one in that had it happen to them.

Moderator: You think that would have more of an impact perhaps than teachers doing it?

Cath: Mm.
John: They haven't experienced it.
Moderator: Yeah. Any other ideas?
Cath: Some one with experience should go in and say something.
Moderator: And not hold back on the shocking things are you saying.
Cath: Yeah.
Moderator: But do you think it would make a difference.
John: Not really
(laughter)
Cath: I don't think it would to most of us.
John: Too late now;
Cath: Yeah, 'cos most of us are to into it and that.

School 10, focus group 02, 2males, 3 females, 4= White, 1 = South Asian, 10/11/97

John and Cath's remarks suggest that decisions about how to package drug education messages need to be made in the light of knowledge about the stage that pupils are 'at' in their drug taking careers. Comments from other pupils confirmed this impression. The research frequently encountered the idea that lessons come too late to have a deterrent effect on those most susceptible to the attractions of smoking, drinking and drug use. Pupils who saw themselves as 'hardened' smokers were also against messages that made them feel 'bad' about a practice they perceived as out of their control.

In another focus group suggestions for how drug education could be better handled relate well to points made when data on *subjective attitudes to health* were presented.

Sheila: I don't know how you could make it different, but it just doesn't work. The amount of people do smoke, and they're showing all these don't smoke videos, and all these adverts on the tele, and it's a waste of time, it's a waste of money.
David: They tell you it, but it don't hit you like it should. Like they think it should. Like they think it's got through to you, but it hasn't.
Moderator: Do you think personal experience has more impact.
Helen: You don't know how bad things are until you see it happens.

Steven: Like an advert, it would be better if it said something like 'It's your choice', that sort of thing. Not like incriminate people. You turn round to people and you say 'It's wrong to smoke or you'll end up like this' they just think, 'I don't care, I'm going to do it anyway.'

School 04, focus group 01, 3 males, 3 females, all White, 05.02.98

Although John uses the word *incriminate*, the context suggests that he is personally opposed to drug education approaches based on techniques designed to *indoctrinate*. In this he was very far from alone – a finding that highlights the needs for messages that can not be readily construed as biased - and for sources that are 'obviously' trustworthy and believable.

The qualities and capabilities of the source

Pupils' comments suggested that, from their point of view, one of the issues which detracted from the value and benefit of school-based drug education was that it tended to be placed in the hands of deliverers with a low level of expertise in the subject. This negative perception seemed to be based on subjective judgements about teachers' lack of knowledge of the social realities (as opposed to biological facts) about drug use. The following comment epitomises the sorts of ideas expressed.

John: Teachers don't know what goes on. They don't know street names or anything. We know more than them because of what we pick up on the streets.

school 07, focus group 01, 3 males, 3 females, all White, 25/11/97

In the next fragment attention is drawn once again, to the perceived propensity for brought-in speakers with expertise on the subject to make a better job of health education delivery

than 'ordinary' teachers.

Sheila: I reckon it's so much better when you have like professionals come in and do it. At junior school we had this woman and she was talking about periods and stuff like that. You're so much better off when you learn from people who know what they are talking about than teachers who have just read a fact sheet.

school 04, focus group 01, 3 males, 3 females, all White, 5/2/98

That some teachers were viewed to be good drug educators is a finding that should not be obscured by criticisms based on pupils' poor experiences at the chalk face. In this focus group extract, the pupils show appreciation of a teacher and suggest that their readiness to take note of his 'advice' is partly linked to his science background.

Fatima: Our form teacher is a science teacher. He's always warning us and giving us advice. He's been really helpful

Mandeep: But it depends what teacher you get. If you get a science teacher they explain it in depth. If you get a maths teacher, they only know about maths – well probably a little bit else, but not the health risks.

Imran: I think specialised teachers know the subject

school 01, focus group 02, 4 males, 2 females, all South Asian, 18/11/97

In other instances the issue that was highlighted was the teachers' ability (or lack of ability) to facilitate two-way discussion on drugs within health education lessons. In the fragment of discussion below teachers with different skills in this vital area of health education delivery are contrasted.

Sheila: Like we're all in the same form (*includes Myles, David and Helen*) and our form teacher, she's just pathetic. I could do it better than her.

Carolyn: Like in science, she can't handle no one.

Helen: She's got her opinions, and she don't see no one else's point of view.

Steven: Mr Finch was good weren't he? He's a good health teacher.

Carolyn: Yeah, he makes it interesting.

Steven: When he did like sex education, he got us all round, and he got us to write things down on paper so he could clear them up. So if you had any questions, he'd read them and he'd answer them.

school 04, focus group 01, 3 males, 3 females, all White, 5/2/98

The following quote is useful because it counters the impression that pupils' experiences of drug education from outside 'experts' were always better than their experiences of teacher-led drug education. It appears that the speaker referred to in such critical terms here favoured an authoritative, 'talking heads' approach that fitted with pupils' 'prejudices' about school-based health education being prescriptive.

Jim: We had a woman come in one week but we sorted her that stupid she never came back.

(General laughter)

Moderator: An outside speaker of some sort?

Jim: Yeah. She was like - a pharmacologist - and she was talking about alcohol and smoking. Like we had a group, and we sorted her senseless. I think she said about 3 sentences in the whole hour.

Brian: Yeah, that was it. We were lively weren't we?

school 10, focus group 01, 3 males, 3 females, 4 = White, 2 = South Asian, 25/10/97

So the evidence suggests that drug educators need to a degree of 'street-cred', non-judgemental attitudes and skill in the use of participatory teaching methods. In addition, the focus groups suggested that there are other 'qualifications' necessary for 'making it' as a successful communicator on drugs in young people's eyes: namely, perceived congruence between words and actions. This finding links to the evidence highlighting the relevance of the whole school environment to pupils' interpretations of and reactions to drug education programmes (see below).

The wider curriculum context.

The view that school-based health education has more impact when messages conveyed through the taught curriculum are backed up and reinforced by the subliminal messages sent out by the 'hidden curriculum' (see discussion in chapter 1) received endorsement in comments from focus groups participants. There were indications that the credibility of health education lessons on smoking and no smoking policies were both undermined in situations where pupils were aware that staff members were smoking at school. Here, for example, the view that it is a case of 'do what I say, not what I do' appears to be caught up in the negative attitudes expressed by Greg and Gemma.

Greg: I think they give them talks to make the school look good. Like most of them smoke anyway. Like at dinner time I saw two of the teachers in the bushes. You walk by having a fag and they are having one as well.

Gemma: Like the other day we saw one of the teachers smoking. So like, they can't really set the standard for us if they are breaking the rules.

school 09, focus group 01, 4 males, 3 females, 6 = White, 1 = South Asian, 19/3/97

Through this last comment Gemma draws attention to the enforcement of her school's no smoking policy. Generally speaking there was support (albeit mainly tacit) for policies designed to make schools 'no substance zones'. The 'sense' of not allowing drugs in schools appeared to be widely accepted (even to pupils who were using cannabis on a regular basis). Non smokers often spoke of their 'disgust' at the state of the smokey toilets they were expected to use and there were no occasions when smokers condemned school smoking bans out of hand. What was resented was the perception that there was one 'rule' for pupils (who at 16 were legally entitled to smoke) and another for teachers. Also the

perception that the 'policing' of policies was heavy-handed or insensitive.

Moderator: What happens if they find a pupil smoking on the school premises?

Jim: You get a letter home.

Vicky: No you don't. I got caught today. I was standing round the corner having a fag, when all of a sudden, I gets this tap on the shoulder - and I go 'Who's, that' and I turn around and it was Mr Collins behind me.

Jim: It all depends what teacher you get. Mr Collins, he's new in the school, but he's a laugh and a half.

Vicky: He's super I love 'im

Jim: You could drink a can of beer and he'd just probably say, put it away.

Brian: And then you get some people - Mr. Howarth - he'd just ask you to walk away from the school and smoke it. If it was younger people, they'd be more strict.

Vicky: Because we're Year 11, because we're all near enough 16 anyway.

Moderator: You think they're a bit more liberal with you - but stricter further down the school?

Kiran: It's hard to tell because some of us are 16 and some of us aren't. The teachers know who do it, and they know that telling them to put it out ain't going to stop 'em. They just like - leave it after a time.

Moderator: Leave it?

Kiran: It's like when they catch someone in Year 9 they will step in, but because we're Year 11 - they'll advise you - please don't do it on the school.

*school 10, focus group 01, 3 males, 3 females, 4 = white, 2 = South Asian,
25/10/97*

Comments in the extract above contribute to the general impression (strengthened by the evidence in the next Chapter) that it is very hard for schools to get it right in respect of drug prevention. The implementation of the no smoking policy in this school was clearly not very effective from a deterrent point of view. On the other hand teachers adopting a low-key approach to it's enforcement in the Year 11 context signalled their respect for the 'rights' of individuals to make legal choices and, in the process, avoided antagonising an important section of the audience for health education.

5.3 Summary of findings

- The most immediate influences on pupils' receptivity to health education on drugs were subjective ones. Most notable were the following: their attitudes to health, specifically their judgements about the *urgency* of the need to protect it. Their values (as reflected in their views about the ethics of various substance-linked behaviours) and their subjective views on the value of substance use in relation to their emotional needs (for self-identity and for pleasure and fun as a means of offsetting and coping with stress).
- Shaping and moulding these subjective dispositions in subtle ways were the social realities of pupils' immediate lives. The norms pertaining in friendship networks were important in this. So, too, were family influences (parental and sibling example, expectations, imposed restrictions) and conditions at school (the physical and the social environment).
- Conditioning the previously highlighted influences were operating at macro-level. Notable contextual features included the traditional norms affecting pupils in the South Asian sub-group (particularly the female and/or Muslim young people) and the social development of a growing normalisation of recreational substance use within youth sub-culture.
- 15-16 year olds tend to come to the chalk face with dispositions that make them challenging candidates for persuasion on the advantages of substance-related risk taking avoidance. The need to engage them is not helped by the following tendencies.

- Organisation of drug education within a curriculum context that is perceived to be low status by pupils
- Over-reliance on one-sided messages ('unbalanced' and 'unrealistic' approach) which suggests to pupils that there is a moral agenda behind their drug education lessons
- Resort to teachers who lack the skills and confidence to deliver the programme effectively.
- Inability to ensure that the programme is fully supported by the 'hidden' curriculum.

5.4 Discussion and conclusions

In the concluding section of the chapter the findings identified above are discussed in the light of models and theoretical frameworks reviewed in chapter 2. Where appropriate links are made with the conclusions of qualitative studies that took substance-related risk taking and youth as their focus.

The finding that an individual's **subjective attitudes towards health** have an effect on their receptivity to health education arguments can be related to the construct of 'health threat', a common element in a number of the leading theories (social cognition models) applied to the design of health education interventions (Nutbeam and Harris, 1999). There were echoes of both dimensions of this variable – perceived seriousness/ vulnerability to a

given health threat in the empirical data. Pupils whose reaction to drug education was characterised by broad acceptance of health education messages on smoking, illegal drug use and under-age were inclined to take the attitude that they could not take their health for granted/ that they needed to actively protect it. The experience of **critical incidents** sensitising them to the unpleasant consequences of substance use influenced this attitude in some cases.

Pupils with a more selective approach to information and ideas encountered in drug education lessons had a contrasting approach. This seemed to be influenced by the calculated view their youth conferred some (temporary) ‘immunity’ to health damage and could postpone the need to preserve it through the avoidance of behaviours that were detrimental to it. This links with social-psychological insights about the tendency for young people to operate with a sense of personal invulnerability in the face of threats to their wellbeing (Elkind, 1967; Jack, 1989; Jeffrey, 1989). It also throws light on the limited impact of health education on 15-16 year olds: a key aspect of the quantitative findings presented in Chapter 4. Also relevant for explaining this finding is the evidence on the theme of the **nature and balance of messages in programmes**. The empirical data suggest that school programmes tend to over-rely on messages about the negative implications of substance use for physical health. This does not imply that information about health risks is not an integral part of drug education in schools – on the contrary, the findings backed the conclusions of Roker and Coleman (1997) regarding young people’s interest in *timely* inputs of ‘straight facts’ to support their substance-related choices. It does

suggest, however, that a greater emphasis on information highlighting short-term and/or other risky dimensions of substance would have the potential to improve perceived message relevance and improve the prospects of pupil's experiences at the chalk-face being positive.

The finding that an individual's **principled beliefs** have an effect on their receptivity to health education highlights a deficiency in social cognition models of health behaviour. The omission, within these frameworks, of beliefs reflective of deep-seated values is noted elsewhere in the literature (Connor and Norman, 1996). Judging from the findings of this study this theoretical blind spot is problematic in the substance use context because ethical judgements about the issue can have a real impact on personal behaviour. Many of the pupils whose drug-related choices (and, by association, acceptance of drug education arguments) had been shaped by their 'principles' had experience of an upbringing within a religious framework. Muslim pupils were heavily over-represented in this group, a finding that triangulates and helps to explain the patterns in receptivity to health education (and practice) highlighted in Chapter 4.

A principled 'take' on things was not the sole preserve of young people influenced by religious teachings, however. The implication of this for practice is that there might be mileage in exploring the use of approaches that take the development of ethical reasoning skills as their educational goal. Citizenship classes, which have recently been made a compulsory element of the curriculum for pupils at Key Stage 4 (DfEE, 1999), provide an

obvious delivery context for such approaches. However, evidence relating to **curriculum context for drug education delivery** suggests that this may not be the best way forward. Pupils' willingness to engage seriously with ideas and information relevant to their personal choices appeared to be adversely affected by the perception that non-examined subjects 'don't count'. This obstacle to communication is somewhat akin to the empirically established obstacle of a non-credible source. (Interestingly, the perception that PSHE teachers were non-specialists emerged as off-putting in it's own right). The implication that can be drawn from this is that the integration of ethical reasoning skills in more 'mainstream' academic subjects (scenarios involving drugs could provide a useful way for pupils to link 'principles' to practice) could hold more promise.

The finding that receptivity to drug education messages is negatively affected by positive perceptions about the value of substance use in relation to image and **self identity** accords with insights on voluntary risk taking within the literature on the social construction of risk (Lupton, 1999). It also tallies with sociological analyses that relate specifically to substance-related risk-taking and youth and which point out the way that participation in smoking, drinking and/or cannabis use can meet young people's needs for affirmation and a sense of autonomy (Lloyd and Lucas, 1998; Denscombe, 2001). On the basis of research with smokers of a similar age to the ones in this study Lloyd and Lucas arrive at the recommendation that professionals should confront the uncomfortable fact that many smokers enjoy smoking and get something positive from it. This research reported here adds to this debate by highlighting implications for the **nature and balance of messages**

in drug education programmes. In this regard pupils' criticisms of their experiences suggested that programmes are mainly comprised of items of information, packaged in one-sided messages, that emphasise the costs of substance use. Research in the social-psychological tradition suggests that such messages are not very effective when the audience has awareness of counter-arguments (inevitable given the current prevalence of smoking, drinking and drug use amongst secondary school pupils). Neither are they effective when receivers suspect that an attempt at persuasion is under way (often assumed by the pupils in this study despite the formal educational aims of the programmes – see next chapter). This suggests that a shift towards a more balanced treatment of substance-related issues – reflected in an increased profile for messages which also acknowledge the benefits of substance use - could improve the value of drug education programmes to recipients.

The young people in this research perceived that substance use was beneficial to their enjoyment of leisure and their ability to cope with the pressure of GCSE course-work and exams and these are important facets of young people's social situations. This theme highlights the relevance of wider social factors for an individual's receptivity to drug education messages. Findings about the value attached to the mood altering effects of substances support empirical findings from qualitative studies of young people's substance-related behaviour (e.g. HEA, 1998). They also endorse the sociologically framed understandings of youth and their risk-taking that have started to appear in the literature

(see France, 2000 for review). The finding that the young people in the research viewed (substance-lubricated) leisure time spent with friends as a good means of relieving tension and pressure is interesting in the context of the sociological interest in the relationship between pleasure and risk taking. The concept of work-life balance has recently achieved high profile in popular discourse and it is likely that this contributed to the pupils' readiness to use this concept as part of their explanation of motives. This does not mean that interest in achieving a personal interpretation of this 'balance' has no real and potentially negative implications for receptivity to health education arguments. The issue of the desirability of acknowledging the 'positives' of drug use is highlighted once again. The other implication that can be drawn is that schools may have a potentially useful role to play in improving young people's access to knowledge and other resources that could assist them to cope with stress in a 'healthy' fashion. [N.B. It has been argued that that GCSEs constitute a new and distinct source of stress in the already stressful lives of young people and that pupils' sense of being under pressure is socially conditioned - see Denscombe's (2,000)].

Findings about **friendship networks** and their influence on young people's receptivity to drug education arguments provide something of a challenge to the crude peer pressure thesis that has had such an impact on the historical development of approaches to drug education approaches (see Chapter 1). The findings support the analysis (Coggans and McKellar, 1994) that peer alignment rather than peer pressure is a better way to conceptualise the processes at work. The data further expose the fallacy that young people

are victims of unwanted pressure to use substances from their friends. This finding has implications for the current endorsement of drug education approaches premised on the understanding that drug use is indicative of a lack of skills for resisting peer pressure at policy level.

The finding about the influence of **family context** on receptivity to drug education can be linked together with the influence of friends on the basis that interactions with both sets of people are vital elements in young people's lives. Parental influence appeared to be an influence on the restrictions some young people were imposing on their substance-related behaviour (and, as findings in Chapter 4 demonstrated, there are positive links between behaviour and uptake of health education arguments). This finding links with those concerning normative influence to the extent that these pupils were highly aware that their parents did not consider they should be taking substance-related health or legal risks.

...

There are also interesting links with evidence on the theme of the **qualities and capabilities of drug education deliverers**. The perceived shortcomings of teachers encountered at the chalk-face highlighted the importance of sources that can command credibility in the eyes of receivers (see discussion of Yale research programme into effective communication in chapter 2). The evidence suggested that parents whose credibility as sources of advice on drugs was compromised in their children's eyes were in a poor position to provide the reinforcement of health education messages that school-based programmes require for optimal impact. This finding has implications for policy

because it highlights the need for realism with regard to the scale of the contribution that schools can be expected to make to policy goals on smoking, alcohol or illegal drugs.

The traditional **cultural norms** surrounding the upbringing of a high proportion of South Asian pupils in the study emerged as a strong factor in the tendency for this sub-group to react more favourably to drug education than their White peers. This helps to explain the ethnic patterns in the quantitative data presented in chapter 4 and endorses the principle commended to schools (DfE, 1995; DFEE, 1998; DfES, 2004) about the need to plan programmes on the basis of knowledge about pupil's cultural background and social experiences. The obvious link here is with the notion of outcome expectancies as embedded in leading models that explain health behaviour by focussing on individual characteristics (Nutbeam and Harris, 1999). Pupils had heightened perceptions of the costs of transgressing cultural norms around smoking, drinking and drug for self (and family) and judged that the possible benefit's were not worth it. In instances where the opposite judgement was arrived at **sub-cultural norms** appeared to have more relevance. The key sub-cultural norm at work concerned young people's view that drinking (and, to a lesser extent, cannabis use) was fairly unremarkable with their age group. This finding links with the sociological thesis that recreational substance use is becoming increasingly normalised amongst young adults (Measham, Newcombe and Parker, 1994) and provides another basis upon which to argue the need for realism in relation to what school-based drug education can be expected to achieve.

The finding that the widespread **social availability of drugs** was an influence on pupils' uptake of drug education arguments links with perceptions of control as embedded in leading social cognition models of health behaviour (Connor and Norman, 1996). This relates to an individual's perceptions of the ease or difficulty of performing a given behaviour and encompasses perceived internal and external barriers. The young people in this research thought that access to alcohol and even illegal drugs posed no major problems if they *wanted* to get hold of them. (The notable exception was Muslim girls because of the restrictions imposed on their social movement). Evidence relating to the **wider context of drug education** highlighted criticisms of the way that no-smoking policies operate in school. At the same time it suggested that pupils with 'healthy' substance-related intentions appreciated rules and restrictions designed to support their healthy choices. This validates the current policy emphasis on schools as being drug-free environments but raises the issue of the limited ability of schools to affect the social environment of pupils once they step beyond the gates of the building. This emphasises the importance of drug control strategies focussed on the supply side of drug control and the need for modest expectations about what school-based efforts to protect young people from drug-related harm can achieve.

In general, the findings support the conclusion that the individualism and the diversity of social experience that young people bring with them to health education lessons is the underlying reason for the uneven (and limited) impact that programmes of drug education achieve. Pupils who come to lessons already inclined toward healthy substance-related

choices value their experiences of drug education and this is positive from a policy perspective although it's contribution to the achievement of strategic goals is hard to quantify. (The fact that pupils who are not disposed toward message acceptance encounter communications that are poorly geared to their beliefs, interests and social experiences is, in contrast, of great concern from both a policy and a youth-focussed perspective). A more effective implementation of principles of good education practice would appear to be needed.

CHAPTER SIX

Teachers' perspectives on the delivery of drug education in schools

This chapter presents and discusses qualitative findings obtained from in-depth interviews with teachers responsible for the co-ordination and strategic development of drug education in the five case study schools. The findings in the first section of the chapter show that informants were operating on the basis of the current state of knowledge about what works best in drug education. They also highlight recognition of the social limits on the effectiveness of programmes. The findings in the second part of the chapter provide rich insight into factors supporting and constraining the development of drug education practice in institutional contexts. The chapter concludes that the failure to fully embed principles in practice is linked to time restrictions, an under capacity in confidence and skill on the staff and excessive caution about the type of drug-related interaction that is acceptable at the pupil-teacher interface. It acknowledges that the government's provision of additional resources for training and curriculum development has offered schools an opportunity to strengthen their drug education provision. At the same time it argues that co-ordinators' ability to capitalize on this is constrained - notably so in 'conservative' institutions characterized by a narrow academic ethos, low investment in health education and a tradition of a management imposed approach to change management.

6.1 Understandings about principles of good drug education

The findings presented in this section suggest that respondents' understandings about what constitutes good practice in drug education are closely in line with official thinking as conveyed in official guidelines that have only recently been replaced by the New Labour government (DfES, 2004a). They cluster around three themes – each of which links to a central tenet of good practice as promoted in the guidelines that were current at the time of the fieldwork (DfE, 1995a – see Appendix 1)

The desirability of a life skills orientated model of approach

The informants were united in the view that the encouragement of 'healthy informed choices' is the appropriate aim for school-based programmes of drug education – an anticipated finding given the prominence of this phrase in the formal policy documents obtained from the case study schools (chapter 4). They also presented a united front on the question of the type of approach that should characterize programmes. In their assessment, young people needed information to help them make healthy decisions in relation to substance use. In addition, they needed skills in areas like decision-making and personal effectiveness. The following two quotes support this finding. The first is taken from an interview in School E, a multi-cultural community college on the edge of the research-area's main city. The teacher featured had strategic responsibility for the school's personal, social and health education programme and his ideas about what health education input should set out to achieve are very much in tune with Government thinking on the subject.

James: Making informed healthy choices. We're not involved in trying to say to the students 'You must do this and you mustn't do that'. We're actually trying to give them information and background so that they can make decisions based on a reasonable amount of knowledge and understanding. Also, to give them some skills and to try to look at the issues to do with saying no. So hopefully we're not trying to preach to them – they don't respond well to that.

Interview with Vice Principal, School E, 9/2/99

In the next quote the drug education co-ordinator of school C, an ex-grammar school that supplemented conventional science-based input on smoking, alcohol and illegal drugs with additional lessons, delivered by science teachers, but run on health education-lines, is negative about a simplistic, 'say no' to drugs approach.

Tom: What we want is to raise students' awareness about the dangers of drug use. We will give them full, frank and up to date information, as far as we can – although it goes out of date very quickly – about the short and long term effects of substance use. We inform students about the legal position and put students in a position when they can make informed choices about drug use. Those are our aims (refers to sheet of aims covering the points he has just summarized) You will see that those activities in this folder (refers to a set of teaching resources), although boringly presented, are designed to reflect those aims. We have deliberately rejected the 'Just say no' theory because our experience is it doesn't work. In fact we almost feel that teenagers will say 'Yes' if their teachers tell them to say no.

Interviewer: So it's a very pragmatic approach?

Tom: Yes. I think it's got to be. We are conscious that drugs are quite freely available (refers to town in which school is located). We have certainly had some incidents this year of students selling drugs in school, although whether they're just obtaining for friends is a moot point. So illegal substances are out there and all our young people will be offered them. The vast majority, by the time they reach 16, will have come into contact with illegal substances, unfortunately some of them very unpleasant substances. We're not just talking about soft drugs, we're talking about serious drugs as well. So we don't say 'no' we say: 'these are the consequences. If you do this, then these consequences may follow'.

Interview with Head of Science, School C, 8/6/99

The challenges associated with educational attempts to encourage contemporary young people make healthy substance-related choices was a recurrent theme in the interviews and there was a great deal of shared recognition that getting over the 'facts' was the easy part of the task. The sentiments expressed in the quote below are typical of those expressed. Mark was the health education co-ordinator of school D, a community college situated on the outskirts of a large University town and here highlights the value he attached to skill development in the health education context.

Mark: They need knowledge so they know what they are doing, so they can make this informed decision. Unfortunately when some of them make the informed decision they can't stick to it. That's the whole crunch for me. It's easy to give them the information but not so easy to give them the skills.

Head of P.E. School D, 19/2/99

Rejection of a model of health education approach that attempts to *impose* health choices did not mean that the teachers were uninterested in *influencing* pupils toward the voluntary take-up of expert advice in relation to substance use. On the contrary, the interviews provided the strong impression that teachers with responsibility for the implementation of drug education programmes felt they had a duty to try and get over ideas and arguments that could potentially protect their pupils from harm. On the question of how best to do this there was also a strong measure of agreement. All of the informants argued that the communication of information about the risks and negative consequences associated with smoking, drug use and drinking was an essential role for school-based drug education.

Ideas about the need for this in the light of social developments making substance use more socially acceptable and ‘normal’ were also expressed. The viewpoint is well captured here. The speaker is Ben, the teacher with day to day responsibility for implementation of the drug programme in multi-cultural, suburban school E and his comments highlight a realistic assessment of the uphill task of school-based drug education that all other informants shared.

Ben. As teachers we can’t step outside of society and turn back the social tide but that’s not to say we shouldn’t do anything about it (*the drug problem*). I don’t smoke and I don’t drink and I use my personal experiences, when I can, through assemblies and so on. But I’m also quite liberal in that I think we should talk to people about it, but ultimately people have the right to choose about it, however misguided I may think their eventual choice might be.

Head of Year 10, School E, 24/2/99

Propaganda for ‘healthy choices’, in contrast, tended to be rejected as unethical and unlikely to work. A respondent who departed from this ‘line’ is featured in the excerpt below. His school was a market town-based community college that used Careers as its main vehicle for PSHE delivery. Here he tentatively suggests that there may be a place for ‘strong’ persuasive tactics in drug education programmes.

Brian: The only reservation that I would have with that (*healthy, informed choices as the aims of the school’s drug education policy*) is what are you actually teaching them? Are you actually teaching them everything they want to know in terms of content, and risks and effects of drugs and then leaving them to make their mind up. Are you not putting any bias what-so-ever? I don’t know if that’s a teacher’s role. I mean you’ve said that about bias, about them wanting both sides of the argument. That (*indicates to the trigger statement*) is assuming that you just leave it open at the end.

Interviewer: But the fact that there's the word healthy – it says *healthy* choices – would you say that there's an assumption that the healthy choice *is* to avoid drug misuse.

Brian: That's it. But is there a choice, in that sense.....? I don't know. That's the difficulty isn't it? Obviously nobody says 'don't do it' anymore – that's gone – but is the assumption, after everything we've gone through, if you've gone through superb lessons, factual lessons with all the information, then it will work? I don't know. How strong has it got to be?

Careers/PSHE Coordinator, School A, 28/1/99

Also dissenting from the idea that drug education inputs should be entirely based on rational arguments was the respondent from School C. On one hand, he acknowledged, a powerful resource like 'Sorted', a video circulated to schools in the wake of the Leah Bett's death from Ecstasy, could be considered educationally flawed because it distorted the facts of the matter.

'the trouble with (*the Sorted video*) is they know very well that Ecstasy doesn't kill you. They know that there are more deaths related to alcohol. They know their friends are taking it and not dying'

Interview with Head of Science, School C, 8/6/99

On the other hand it was worth including in a drug education programme because it did seem to make an impact – after the showing, he recollected, you could have heard a 'pin drop' in the classroom.

The importance of a school environment supportive to healthy choices

The view that school-based drug education programmes need to be backed up by supportive policies characterizes the Government's drug prevention guidelines to schools

(DfE, 1995a; DfEE, 1998) and, judging from the evidence, was viewed as the 'ideal' situation at local level too. Informants' comments indicated broad support for the longstanding health education orthodoxy that school-based programmes of health education will have more impact if the messages conveyed in are backed up by subliminal 'messages' in the 'hidden' curriculum. In practice, most of them indicated that the creation of environments conducive to healthy choices was mired in difficulty. The following extract highlights a problem that many of the informants mentioned in the context of discussion about their experiences of implementing non-smoking policies.

James: We had various meetings that involved teaching and non-teaching members of staff and it was put to a vote and we created a non-smoking campus about five years ago. But there are major problems because we have teachers who find it quite difficult and there are problems with rooms being used by teachers who do smoke. There aren't many, but there's a few, who smoke in the toilets, which isn't very pleasant. Then you've got the sixth formers.

Interviewer: Who are legally entitled to smoke.

James: Yes, and that causes a problem because there are a group of those who smoke between lessons, because they are addicted, they have to go out and have a smoke. Then we have problems with the lower school who are not supposed to smoke anywhere on the campus but who obviously are smoking. We try to stop it and to discipline them if they are caught smoking. We encourage them to go off site but it is a problem for some of them because they are addicted and they are desperate to have a cigarette by the time they get to break or lunch time. We do see them outside the building, although of course they usually go to places that teachers don't go. It's a problem that has been going on for years and years.

Vice Principal, School E, 9/2 /99

Here, again, the theme of a discrepancy between the policy as it appears on paper and the policy as it works in practice is apparent.

Interviewer: (*Indicates to copy of policy document*). You've obviously developed a very impressive policy on the management of drug-related incidents.

Mark: Yeah.

Interviewer: So reading it, it covers how it was developed – with the involvement of the governors, staff and so forth, its aims and objectives. Is the implementation of the policy proceeding as you hoped?

Mark: Its not being implemented too well at the moment. I asked for a meeting before Xmas and I still haven't had one. Things are sliding, its not being done as efficiently as I think it needs to be done.

Interviewer: So you'd like to go back and revisit it?

Mark: Well we need to, regularly, because one of the things that we stated was that every six months we would look at what we have got written down and, if somebody's been in there for six months and nothing else has happened then we'll destroy the documentation that we have on them. I think that's important rather than having it lying around in a confidential file. Nevertheless, we need to monitor consistently and I'm sure we've got - I *know* we've got some folders on new Year 10's who haven't settled and who've got some social problems.

Interview with Head of PE, School B, 9/2/99

The need to operate policies in a fair way was shared by other informants and provided further insight into the challenges of drug-related policy in the school setting. This quote graphically highlights the ethical dimensions of initiatives designed to create supportive environments for healthy choices.

Ben: Some of our responses (*in relation to the no-smoking policy*) are bizarre. We've locked all the toilets in an attempt to stop people smoking in them but what does that say about other parts of the PSE curriculum? We're saying students can't be trusted. We're denying them the human right to use the toilet at certain times.

Head of Year 10, School E, 24/2/99

An interview in School D, a community college based in an ex-coalfield area, yielded an interesting perspective on policies supportive to curriculum-based drug education. This school had a non-smoking policy but the Vice-Principal and Head of Year who shared responsibility for drug education were resisting the idea that they should formulate a formal policy on responses to drug-related incidents on the premises.

Jack: We tend to back away from something that is actually hard and fast because we try and take circumstances into account. Like the guidance we had. Just because somebody brings cannabis into school, does that mean they are automatically suspended or not? I think there is a grey area, an area for discretion which perhaps you could formulate into a policy but we don't, at the moment.

Interviewer: There seems to have been a retreat from the zero-tolerance line under New Labour.

Lesley: Yes. A 'naming and shaming' policy is not particularly helpful in this context. We're acutely aware, of course, if there are drug-related incidents in this college, then we're on to a hiding to nothing in terms of the local press, and in terms of public perceptions. Whatever strategy we decide to adopt – whether it's the zero-tolerance approach, or whether it's a more sympathetic approach – either way we will get criticized in the local media. It literally is a Catch 22 situation. We're bound to lose.

Interview with Vice Principal and Head of Year, School D, 10/2/99

The perception that the institution was vulnerable to criticism on its approach to drug-related incidents underlines the influence of wider social factors on drug-related policy action at school level. The next set of findings confirms this insight by indicating that concerns about 'socially acceptable' approaches limit programme planners' scope to tailor the input to the audience.

The need to take pupils' characteristics and experiences into account

It is an accepted principle of good drug education practice that schools take account of 'the age, sex and cultural/social background' of their audience' (DfE, 1995a: 23). Where clear consensus does not exist is on the issue of whether teaching materials geared to 'harm minimisation' (Cohen, 1992) are appropriate for use in the school context. The Major government's pointed exclusion of teaching materials based on harm reduction principles from the official *Digest of Drug Education Resources for Schools* (DfE 1995b) sent out a strong message about the unacceptability of such approaches in work with school pupils. A message not unequivocally contradicted by the New Labour government which has endorsed such approaches, but *only* in the context of drug education programmes undertaken with young people who are 'disaffected, disadvantaged, or (who) have disappeared from formal schooling' (DfEE, 1998: 41).

Judging from the evidence, the view that school-based drug education programmes should be totally geared to primary prevention goals does not entirely hold sway at local level. On the contrary there was considerable support for the idea that pupils with involvement in drinking and/or experimentation with illegal drugs stood to benefit from advice and information about ways they could enhance their safety. The Vice Principal of School E felt particularly strongly on this matter and had taken steps to ensure that there was wide support, within the school community, for the incorporation of a harm reduction focus into the drug education programme offered by the school.

Interviewer: So harm-reduction is not a philosophy that runs against the grain in this school? There are schools of thought that don't approve of that approach.

James: Yes, I know.

Interviewer: What's your feeling about that?

James: Well we are very keen that we should push ahead with treating it as harm reduction – assuming that students will try things and that if things go wrong, this is what we should do. When we discussed this with governors, we went through it with our parent and teacher governors, they were very keen that we should do that as part of our drugs education as well as just giving people some background knowledge as well.

Interview with Vice Principal, School E, 9/2/99

Others teachers supported the idea of harm-reduction *in principle*. On the basis of not feeling confident about reactions to harm reduction message, however, they had 'played safe' with the content of drug education lessons and stuck to teaching materials that highlighted the benefits of stopping or, preferably, never-starting to experiment with smoking and drug use. The most outspoken on this topic was the Head of Science in School C. A trickle of past complaints in relation to the sex education component of the health education programme had convinced him that a highly cautious approach was needed in relation to lesson content.

Tom: If teachers want to do any activities that are not in the folder then they must be personally approved by me. And I'm very conservative. I'm not going to endanger my pension by people being racy'.

The backdrop for this remark is Tom's concern that none of his team said anything that could be interpreted as suggesting they condoned the use of mood-altering drugs. In

common with other teachers, he had been unsettled by the recent bad press attracted by a school nurse undertaking sex education lessons with a group of secondary school pupils in the North of the country. The factual answers she had given to pupils' enquiries had been interpreted as 'encouragement' for sexual experimentation and, for him, had highlighted a need to play 'very safe' with health education. The case of alcohol was rather different. Informants viewed information geared to harm reduction as pertinent to a high proportion of older pupils and most indicated their belief that the delivery of messages geared to keeping young people as safe as possible when drinking would probably be fairly uncontroversial in the upper school context.

6.2 Factors shaping delivery practice in institutional contexts.

The evidence in this section is based on two lines of questioning. The first related to the historical background to current delivery arrangements; the second to thoughts on the issue of whether the 'standard' of drug education provision in the school was improving, staying static or declining. The responses suggested that arrangements for drug education delivery at school level are the outcome of a long process of modification and refinement in response to changing circumstances and demands on the organisation. To emphasize this insight and to tie the findings in closely with the conceptual schema which proposed that delivery blueprints would be influenced by a combination of internal and external factors a cameo approach is used to present the findings. An important caveat is that the cameos are based on a small number (two at most) of informants per school. These informants were

chosen on the grounds that their strategic and/or day to day responsibility for the implementation of their institution's drug education policy would give them an interesting stakeholder perspective on the process of drug education. There is no attempt to suggest that this perspective represents the definitive 'truth' about drug education delivery in the five schools.

School A

Current model of organisation: drug education is part of a PSHE programme that places heavy emphasis on 'careers'. A small team of teachers (as opposed to form tutors) is responsible for the delivery of the health education component of the programme.

Rationale for current delivery arrangements

The Head of Careers/ Health Education described how the current arrangements for drug education delivery had remained unchanged for a number of years. When the model was first adopted there had been a number of team members with an interest and expertise in health education and in, his personal judgement, the delegation of the this 'sensitive' (health education) component of PSHE to a specialist team had worked well in delivery terms. One of the team members had held a senior management position in the school and, as well as contributing to the staffing of the programme, she had also proved an effective champion for health education within the organisation. In the mid- 90s she had been the architect of the school's successful bid for recognition as a 'healthy school' under an award scheme run by the LEA in conjunction with the local health promotion department. The

award of this status had resulted in a high political profile for health education within the organisation and had been associated with an annual 'Health Fayre' that supplemented the work undertaken in the taught curriculum by providing pupils with an opportunity to interact with 'experts' manning exhibition stands. Over the course of the last two years this individual and another committed teacher had left the staff. In addition a new Head had recently taken up post.

The old Head had been in the habit of using assemblies as a vehicle for the imposition of his strongly anti-smoking and drug attitudes on pupils in ways that belied the principles that were meant to inform the health education programme. His imposition of a no-smoking policy on staff had also been unhelpful, in the sense that by sending staff smoking underground it had, ironically, made it more visible to pupils. On the positive side his championing of the subject had been very helpful. It had protected health education from losing curriculum time in the wake of the reforms to education embarked on in the late eighties by the Conservative Government. It has also helped secure resources (money and time) for training and curriculum developments purposes.

Unfortunately, over the course of the last three years the loss of key members of the team had led to progressively worsening problems with the staffing of health education within the PSE programme. Brian's own contribution to the delivery of the health education lessons was now stretched to the limit and he was forced to rely on 'conscripts', many of them not very willing, to deliver lessons in timetable slots that he could not cover himself.

In his judgement this meant that standards of delivery were inconsistent, with the result that some pupils in the school were getting an educational experience that, he saw, as sub-standard.

Assessment of prospects for drug education enhancement

The teacher interviewed in School A identified two opportunities that he had been able to capitalize upon in his attempts to improve the provision of drug education in the school. The first was an increased availability of teaching resources to support classroom delivery. The second was his LEA's appointment of a drug advisor with a remit to support programme co-ordinators in the schools through curriculum development advice and other means. Overall, however, he was unhappy with prospects for the enhancement of the quality of drug education in the school because he felt that the logistical problems associated with the existing system of delivery could only get worse. Change to new curriculum model, one in which form tutors were give responsibility for all components of the PSHE programme, was identified by him as the 'answer'. On past experience, though, he doubted whether he would be able to defeat the arguments of those in the organisation who wished to maintain the status quo.

Brian: It (his proposal to change to an arrangement of form-tutors delivering all aspects of PSHE) came up to the curriculum committee again this year because of the problems with staffing and time-tabling. But it was very against it because of the controversial nature of the subject. OK – drugs, I think in a sense a lot of people can cope with that - but there's no expertise. We talk a bit blind. We're in the dark. Certainly the main area that put people off is sex education because there's absolutely no way. And we felt that because it's an important part of the whole program so we couldn't miss it out. You can't pressure people to cover it if they feel uncomfortable with it

This interview extract suggests that drug education delivery decisions are notably influenced by political factors operating at the organizational level. Brian's status as subject head afforded him little command over resources or power within the organisation. Consequently, he was routinely over-ruled in policy forums, by colleagues who viewed the protection of the interests of form tutors as more important than improving the quality of the school's drug education programme. In Brian's view the sensitive nature of health education topics was only part of the reason that the institution was happy to stick to a status quo that was no longer tenable. Also relevant was his colleagues' unwillingness to take on responsibilities requiring extra time and extra effort. This culture of resistance to change was one that Brian could understand, given the high level of pressure on teachers. In trying to counter it, however, he felt he was failing to get support or resource assistance from the senior management team. He wanted to pursue a strategy of developing time-saving, 'off-the-peg' lessons but, to date, had failed to persuade management to invest in this project.

In common with other informants, Brian saw wider developments in the educational system as contributing to his difficulties in defending and advancing the interests of drug education in the school. Management's neglect of non-academic aspects of the curriculum and colleagues' lack of enthusiasm and willingness for health education delivery were both presented in this light. More unusually he went on to suggest that even the most motivated

and well-trained group of delivery teachers imaginable would have problems in facilitating the kind of participatory lessons that represent the drug education 'ideal'.

Brian: I find as a teacher of, now, 33 years that's it's only in a few classes that you can hold a proper discussion with 25 kids. Its changes in attitudes, changes in behaviour, changes in attention spans, inability to involve themselves. Within PSE there are very few opportunities when we can get involved with half group sessions. We don't do one at the moment with drugs although we do do a couple with sex education and quite a number with careers.

(returns to the same theme later in the interview.)

Brian: I tell you honestly what I think the problem with all this is. The ideas of all the lovely drug manuals and the skills to resist are great in theory but there are very few schools that have got the right sort of situation to manage it.

Interviewer: How do you mean?

Brian: I do think that the average teacher can't do that with twenty five kids. Not in the way that you would want to do it. It would need to be a very, very good group. There's just not many situations when you can get groups down to 12 or 13.

Interviewer: You're highlighting an important issue that has escaped me so far. Pressures on time-tabling lead to big numbers in groups and that means that your options with approaches and methods are limited?

Brian: Yes. I honestly think so. Its not a sour note – well, I guess in a way it is – but kids attitudes and behaviours have changed so much over the last few years. It's become so difficult. I think a lot of teachers, particularly those who are not directly involved with it, are forced to things that they feel safe with and I'm afraid that it does sometimes come down to the easy option. To the video and *(tails off)* I'd love a situation where I could work through a social education programme with 15 kids. It would be tremendous. When you're doing the activities. When you're in circles. Things like that.

These insights heavily implicate *time* – the most restricted commodity in the curriculum – as a factor responsible for the discrepancy between drug education practices and 'ideals' and suggest that it is possible to over emphasise the 'correct' delivery model as the key to good drug education practice. Certainly Brian envisaged that the move to a tutor delivered

PSHE model would not effect the need for health education to take place in large groups: a circumstance which inevitably reduced the likelihood that participatory teaching methods would be used effectively. This teacher's perceptions need to be understood in the context of his (unrealistic) desire to return to an era when the educational climate was highly supportive to humanistic enterprises like health education and when his school felt able to prioritise the curriculum development of non-academic subjects. They are, nevertheless, interesting for the way they contribute to the conclusion that in the current educational era the policy instruments being relied on to strengthen drug education in schools are unlikely to achieve the desired end of high quality programmes for all pupils.

School B

Current arrangement: Drug education = part of a broad-based health education course delivered within a PSHE framework by form-tutors. Achievement in the PSHE is certificated under a local vocational framework award scheme.
--

Rationale for current delivery arrangements

The teachers representing the school in the in-depth interview that elicited the following insights were the Vice-Principal with strategic responsibility for PSE development and one of two Heads of Year in charge of the planning and implementation of the PSE program. They described how their current provision had its roots in the Technical and Vocational Enterprise Initiative (TVEI) set up by the Department of Education in the eighties. The LEA had used TVEI money to develop a local vocational framework award that reflected

its 'liberal and humane' educational ethos. The course had a personal, social and health education content that was used as a vehicle for the development of life-relevant skills. School B had been committed to, and involved with, the course from its onset and, over the years, it had become an established part of the curriculum. The joint perception of the two interviewees was that the current arrangements worked smoothly and that the award had a tangible benefit for pupils because its value was recognised by local employers and colleges.

Assessment of prospects for drug education enhancement

Both informants were of the view that the long period of investment in the PSHE programme over a relatively long period had started to show a quality dividend.

Jack: I think that the quality of teaching and learning is actually improving but it's a long road. You start from a perception 'This isn't what I'm trained to do'. 'This isn't my primary focus'. 'I'm a scientist'. 'I'm a humanities teacher' - whatever. And then you're working in a cross-curricular team, and you're teaching out of your area. You're possibly using techniques that you're not at all familiar or confident with. You're being asked to manage group discussion or what ever and you've always been a 'leading from the front sort of teacher'.

Lesley: What we've put in front of people – myself and the other division Heads, we've worked long and hard on this - is an assessment framework, teacher-friendly scheme of work, a central resource base and a mechanism for colleagues to order and plan lessons. To order equipment and AV materials in advance, through the, library, so that the actual planks of the structure are all there. To make it work, to avoid that stress and those pressure points though it does need colleagues to be really forward looking and to plan in advance.

This excerpt highlights a marked difference in institutional context between this and the previous school: namely, a high level of political commitment to social and health-related

educational goals. Whether this commitment would continue to shield the school's health education programme from competition from other curriculum subjects was an issue that the informants saw as moot. In this excerpt their anxiety that the imminent demand upon to schools to deliver citizenship education was poised to throw current arrangements into disarray is highlighted.

Jack: There was a hell of a lot that went on last year. We had the National Records of Achievement Pilot here, and tutors had to deal with that as well. But now a lot of the stuff is now set up and working with this year 10 coming in, the tutors have been apprehensive, but in fact it's actually gone quite smoothly and I can actually feel – there's a kind of trend of improvement. It's not uniform, there are things to do – issues of monitoring quality and all the rest of it – but it is going in the right direction. The problem is the course is set up - we deal with health education, we do a module on RE, we do 3 careers units which include work experience, we've got other stuff. Now we've got to fit citizenship in and I just don't know how ...there's been a collaborative effort here to get something that we feel increasingly happy with. We know what we are doing and it will be successful over a period of time, I'm sure of that. But it's the constant chopping and changing and messing about –we're just so fed up with it.

Interviewer: So the dust never settled before another initiative comes along?

Jack: That's right. We've had to change things around before, it's like a constant, permanent evolution. I think that something we really need is some stability. We're going to have to look at our curriculum model quite radically if we are going to get yet something else into this area.

This excerpt again highlights the fear that hard won advancements in the quality of drug education delivery are threatened and provides further evidence for the conclusion that the wider educational context has a marked impact on drug education delivery decisions at school level.

Lesley: My personal view would probably be that there is less and less room for projects, in the widest sense – like PSHE - and that the pressure is to focus on what counts in the league tables, focus on what is measurable, focus on what is ...

Jack: ... I think what has happened is the fight between a process culture in schools and an outcome, content culture has gone in favor of content. And, in fact, one of the reasons, quite deliberately, that we've actually gone for this program is that, to some extent, it re-dresses that balance. It is highly process-orientated. In the drugs part, for example, they are engaged in looking at surveys of attitudes to drugs, designing questionnaires, collaboratively analyzing results, and so on.

Interviewer: So you're very much concerned with enhancing skills with the Middleshire Vocational Framework?

Jack: Yes. Its looking at process but the content is not secondary, it walks on both feet. They have an equal value and the key skills are assessed through it.

A factor that the informants in this school saw relevant to prospects for the enhancement of drug education which was not raised by other informants was the standing of PHSE, the curriculum vehicle for drug education delivery, in the eyes of students. This excerpt summarises their perceptions on this matter.

Lesley: I think that institutionally we have come a long way since the late 80's - in terms of teachers in classrooms delivering anti-drug education as part of health education. We wanted health education, we wanted drug education to be part of that certificated process.

Interviewer: So do you think that the developments you have described have helped with the status of the subject in the eyes of the young people and the teachers.

Lesley: We think so. For staff, there was a time when they could not view Social and Personal Education as being as serious as other subjects against a background where there were no schemes of work, very little co-ordination and where, to a large extent, it was unclear whether Social and Personal Education should function as a separate subject or as an extension of tutorial time. The only way, I suppose, to demonstrate whether it has or hasn't worked, in terms of increased status for students would be to do what you are doing, some research. One would hope that they can see a purpose and a point to doing it, where as previously that purpose and point was a bit nebulous.

These ideas provide some interesting confirmation for the impression, based on focus groups and interviews with pupils, that the low status of the curriculum location traditionally favoured for drug education delivery detracts from its impact. In particular they strengthen the view that young people are more likely to engage with drug education if they are able to see that this offers them practical benefit.

School C

Current arrangements: No PSHE programme in the school. Drug education and sex education provided in the context of science.

Rationale for current delivery arrangements

In this school The Head of Science described how the arrangements summarised above had characterised the school's delivery of drug education for a considerable number of years. Although conscious that a PHSE framework for delivery was being commended to schools he felt that, on balance, the use of science as a context for sex and drug education represented the 'best model' for the age group served by the school. The main disadvantage was that some science teachers were 'very weak' on the use of participatory teaching techniques such as role-play. In his eyes, however, this was cancelled out by the perceived status of science teachers as drug education experts.

Tom: It's being done by teachers who the students mostly see as being authorities who know what they are talking about. As we get very good GCSE results that's even more so. So they are not having a tutor who is unwilling to do it and who feels unhappy about it. They are getting people who know their stuff.

Head of Science, School C, 8/6/99

Assessment of prospects for drug education enhancement

This teacher was of the opinion that the drug education experiences provided for pupils were very far from ideal but saw no immediate prospects for change. Management's key priority was the maintenance and development of the high academic standards of the school and as part of this the Head was resisting the introduction of a PSHE programme on the grounds that it would 'waste a lot of time to very little purpose'. However, even if this development was 'forced' upon the institution at some point in the future he doubted whether it would get to the root of the problems facing health education delivery. Far from addressing the issue of inconsistent standards between delivery teachers it could actually make the situation worse. Nor would it alter the fact that lesson content and the scheduling of topics was primarily driven by a need to stay within the accepted moral and legal framework.

The extract below highlights his identification of how differing standards of delivery between teachers poses a challenge to the view that an injection of resources, in the shape of in-service training opportunities, can be relied on to enhance quality standards in drug education delivery.

Tom: I have 10 or 12 teachers teaching this programme and some of them will do it far better than others. I think if you choose your teachers carefully you would get

- the kids would get a very good experience. If you chose your teacher badly it would be a very limited experience.

Interviewer: Is there anything that the school does to help people who are lacking in confidence and skills in this area, for example in-service training?

Tom: Not recently.

Interviewer: You mentioned before that there are many demands on a school's in-service training budget at the present time. Is it ultimately down to that?

Tom: That's part of the issue, but personally I'm not entirely convinced about the efficacy of in-service training. The teachers who are willing to take the advice of colleagues will learn the skills any way. Those teachers who don't do that will not learn it through in-service training. They'll go to sleep at the back. That might be the cynic's view, but I certainly don't think that in-service training is the answer to all our problems in schools.

The two extracts below relate to the perceived problem of an unhelpful moral and legal context for drug education work in schools. In the first he draws attention to a strategy likely to have a negative impact on the quality of drug-related communication at the chalk-face.

Tom: The teacher has to start the course by saying 'You mustn't tell me anything that you are doing that's illegal' because that's a nightmare for us.

Here he states that, in his opinion, the value of health education is undermined by a set of social pretences about young people's requirements for knowledge and support in relation to drugs.

Tom: If we put our hands on our hearts we would know that we were doing all this too late. You could argue that we are playing a game here because it's all far too late. We're talking to girls and boys who may be near to 16 about contraception and substance use – they know more than we do.

Interviewer: Play a game?

Tom: I keep on coming back to this point – you’ve got a lot of hard working professionals trying to do the best job they can but, to an extent, we’ve got our hand tied all the time by the legal framework that governs teachers.

This perception is interesting because it underlines the dilemmas of programme planners concerned both to tailor lessons to pupils’ existing knowledge and involvement with drug use *and* to stay within the boundaries of what is considered educationally ‘fitting’ in the school context.

School D

Current arrangement: Drug education = part of a broad-based health education course – the sex and drugs education elements of which are delivered by a specialist teacher in time currently ‘borrowed’ from humanities.

Rationale for current delivery arrangements

In this school the subject head with responsibility for the co-ordination of the health education programme and the classroom teacher who delivered its sex and drugs-related components were interviewed separately. The reason why the featured extracts all come from the interview with the former is that Mary, the specialist teacher who combined her responsibilities with pastoral support for pupils with high need, declined to have her interview recorded. The immediate background to current delivery arrangements is summarised in the interview extract below.

Mark: We’ve lost a lot of time this year, I’m afraid - it’s gone to RE. Because last time we had an inspection we were deficient in the amount of RE that we were

delivering. That was in the cycle with computer literacy, RE and health education. So RE took our time, basically. That meant we had to look for another way to deliver health education. Now it's delivered in humanities time. But, from the students point of view, instead of getting 25 periods over the two years, which wasn't a lot, now they get 9 lessons over the two years and that has to do everything - apart from fitness and stress and relaxation which we've put into PE. We look at diet, we look at healthy lifestyle – heart disease risks, etc. Very little on smoking because they have had a lot on that in High School. We look at what are sometimes called recreational drugs and alcohol because – well in your survey – alcohol was one of the biggest problems. It means in about 9 lessons over two years they don't get anymore than 4 on drugs.

Interviewer: So, to double check, its done in the context of Humanities?

Mark: Well, they're taken out of Humanities for it to be delivered in what we call consultation time. For two divisions, 10R and 11R we don't have time in the curriculum because we don't have the member of staff free at that time so it has to be done in the 45 minutes after school on a Tuesday or Wednesday evening which runs through the year. So it's really been marginalized. Even more so than just being in the curriculum in somebody else's time.

Interviewer: That's interesting. On the basis of the survey I undertook it appeared that the most typical pattern is for it to be done in PSHE.

Mark: Well we do have tutor time but most of it is involved with target setting with pupils and tutors and its virtually all relating to exams, unfortunately, and work experience and careers guidance.

Head of P.E, School D, 9/2/99

Assessment of prospects for drug education enhancement

Mark's perception was that, in recent years, health education had suffered a reversal in its fortunes within the curriculum. Mary's view coincided with his on the matter; she also shared his analysis that, for a combination of reasons, there was little hope of a return to the days when health education had a profile within the school. One such reason was the unwillingness of form tutors to take on more responsibility for drug education delivery.

Mark: One of the reasons it (*health education*) has been left off the PSE programme is that a lot of staff were saying 'I can't do this. I can't deliver this'. And I do appreciate it's a totally different situation from standing out in front of a class – the pupils need to be involved.

Interviewer: So movement to another model of delivery, say in tutorial time, would be a problem?

Mark: Yes it would be a problem because it's easier for them not to have to. The only way around it, and we've mooted this a couple of times but its never been taken any further, is that we have a *team* who would actually deliver it. But the problem with that is what happens to the form groups of the team who are delivering it? If you're all form-tutors and you've got other responsibilities related to tutor-time. How can you do both?

Interviewer: It's the logistics, isn't it?

Mark: Yes, and it is a problem that is really increasing because of increasing numbers of students and decreasing numbers of staff? At one time we has a reasonable number of people who were either co-tutoring or in addition to tutors. Now nearly everybody in the school is a tutor. There used to be some slack. Now if anybody's away, it's the division head. If there's two people away, you're stuck.

Another perceived contributory factor was that the school's current 'preoccupation' with exam results and league tables contributed to the low organizational importance attached to tackling the current unsatisfactory delivery arrangements for health education.

Mark: The reason that the health bit has shrunk is just not enough curriculum time. PSE time is being used trying to raise standards, but is purely exam-based. I keep on saying there are other important things beside exams. They are important but so are the social aspects. Its gone to various committees but they were mixed or divided and in the end it came down to (*mentions Head by name*) making the decision. I was hoping the directive that we've been waiting for on drugs education would be a bit more forthcoming about the suggesting the amount of time but.....(*shrugs*)

Interviewer: You've been disappointed with it?

Mark: Well yes because I thought it was going to say that it had to be on the curriculum. They do some work on drugs in Science but its science-based, not how

we would deliver it (*in health education*). I think it needs a discrete place in the curriculum. I know you could say this goes across the whole curriculum but I'm afraid that's the way it is- things just tend to disappear.

In this school, as in School A, the informants suggested that political factors, cultural factors and wider developments in the educational system contributed to their inability to strengthen and improve the delivery of drug education in their school. On a more positive note they believed that their programme, whilst far from perfect, was of educational benefit to pupils and were able to identify a number practices they considered as 'good' in the drug education context. One was the use of literature and a special meeting (supported by local police and the LEA's drug advisor) to communicate the aims and philosophy of the drug education programme to parents. Another was the inclusion of work on drugs in the informal curriculum provided by the Youth Tutors who shared the college's premises. Lastly a mechanism for obtaining pupils' feedback about their health education experiences, although by no means considered perfect, was also identified as helpful in the context of the ongoing process of review and improvement of lesson content. The informants comments indicated that these practices had been evolving over a period of years. Currently, the main opportunity presenting itself as helpful were the new resources for drug education that had accompanied the Government's initiative to raise the profile of the subject in schools.

Mark: Well I think basically that the government has done a good job producing resources and keeping people up to date. Some of the stuff produced for parents has been very good ... and what's the name of that place in Manchester?

Interviewer: TACADE?

Mark: No. They've done a good job, we use them for alcohol, I mean Lifeline. They've done some very good, up to date stuff that the kids can relate to. It's so good that the kids actually nick it. If you put a poster on the wall it doesn't last long. Very good stuff. Also, we're about to put D.Code on the network which, again is very good and ideal for giving the information. It plays music in the end if you get there. As soon as we're there we'll put it in the newsletter and I think that will generate quite a lot of interest because they can dip in, any break-time, any lunch-time, after school come to that.

School E

Current arrangements (new at the start of the academic year): Drug education = part of a broad-based health education programme, offered in a PSE context and delivered by form tutors.

Rationale for current delivery arrangements

In this school the Vice-Principal with strategic responsibility for PSE development and the Head of Year with responsibility for the co-ordination of PSE in Year 10 were interviewed separately. The following account of drug education delivery draws on both of their perceptions and experiences.

The Vice-Principal described how traditionally, health education had had a high profile within tutor-led PSE but from the late 80s, the curriculum presence of both PSE and health education had gradually been eroded. In his view timetable pressure caused by the demands of the National Curriculum had been the main reason for this. Also significant was the fact that management had wanted to respond to the complaints of form tutor who felt they did not have the background to successfully deliver topics such as sex and drug

education. The low point had come in the mid-nineties. Tutorial time had first lost its place as a 'fixed entity' in the curriculum and then disappeared altogether. Drug education had continued to be provided during this time but without its accustomed PSE context. The model adopted had been a yearly suspension of the Year 10 timetable so science teachers could provide a whole morning of drug-education. Pupils, however, had not responded well to this arrangement.

James: Unfortunately we found that it was only semi-successful. We found from feedback that having a long day just doing drug education had some negatives. The students spent too long doing it. They got bored. You know some of the activities are fine if you perhaps do an hour or so, but to do a whole morning was difficult for the teachers to keep the interest and the motivation going.

As his colleague pointed out, staff began to detect that the absence of tutor time was having a negative effect on a number of aspects of school life.

Ben: I think staff realized the implications, not just in terms of relationships but even in terms of achievement. I think it's a very impersonal system when there isn't a space – not to suggest that tutorial time is in any way a slack time, its not: hopefully you'll see with the aims and the rationale that our programme is tightly organised – but its just a different space in which pupils can exist with adults. And that's important.

Head of Year 10, School E, 24/2/99

These two problems had been fed into the comprehensive curriculum review of the previous year. The decision had been taken to reinstate a tutor-led PSE program incorporating health education.

Assessment of prospects for drug education enhancement

The perception that drug education provision in the school was being improved was shared by both of the interviewees. From their perspectives a number of factors had contributed to this positive development. For the Vice-Principal the inclusive nature of the curriculum review process - the views of teachers, governors and pupils had all been sought and listened to – was signalled as significant. For the Head of Year 10, as the following extract illustrates, one of the key issues was management's approach to change.

Ben: The catalyst (*for change*) wasn't necessarily top down from our management. They clearly wanted that system, but they didn't impose it. I honestly feel that there was a genuine wish within the staff to see something happen. Not all staff, if I am honest, are happy with where we are at the moment but - at least we are somewhere. We are moving forward, and we're debating so that's good. That's positive.

Head of Year 10, School E, 24/2/99

In contrast to school where lack of investment was having a negative impact on the prospects for change to a tutor-delivered, PSHE-based model of curriculum organisation, the resources necessary to support change had been forthcoming in this school. The Head of Year described how key staff had been released from teaching duties so that they could attend an in-house training on the subject. He also explained how he and the Head of Year 11 had been given resources and time so they could plan the new programme in detail and take full advantage of the training they had received. In both these areas the support of the local education authority was acknowledged as significant. The staff-cover money granted to the school had helped subsidise the training costs and the expertise of the drug education adviser who had provided both the training and the curriculum support to ensure that the programme was credible in the eyes of both pupils and staff.

In addition to the importance of time and money in the switch to a better delivery model the informants drew attention to staff members' willingness to participate in change. The Head of Year 10 interpreted the fact that no one had taken up his offer to personally deliver the 'sensitive' health-related components of the PSE programme as a 'vote of confidence' in it from the staff. Here he comments on tutors' reactions to their recent experiences of drug education delivery.

Ben: All the feedback I've had so far has been positive. Some have said 'can we do more'. So we'll try to build in something next year, I'm not sure if we can do that because its very full, but we'll try. They said that the students really appreciated it as well.

Head of Year 10, School E, 24/2/99

The evidence of differences in organisational culture between case study schools suggests that organisational values such as educational ethos, have had an impact on the ability of many of those responsible for drug education programmes to effect positive change. For some time, the informants in this school had felt that external pressure to raise standards had resulted in PHSE occupying a low position on the organisation's agenda. A strong commitment to the promotion of pupils' physical, mental and social health had survived within the school, however, and was now reasserting itself in the shape of a collective effort to review and strengthen non-academic areas of the curriculum.

This is very much in line with the official policy aspirations (DfE, 1995a; DfEE, 1998) but informants felt it owed relatively little to top-down policy input.

Interviewer: I'm struck that you have 'fine tuning' your provision of drug education over a period of a number of years. To what extent would you say that the recent changes and adjustments you have made in your provision of drug education have been influenced by outside imperatives to improve it?

James: They weren't what drove it. There are enough teachers in the college to support the view that drug education is important. There are some cynics, obviously, but I think there are sufficient numbers of us to support the view that students should be given space to discuss issues to do with health education.

Vice Principal, School E, 19/2/99

Such comments are interesting because they support the bottom-up analysis that policy does not necessarily originate 'from the top' but may be a result to pressures or problems on the ground' (Barrett and Hill, 1984: 219). The informants considered that an important barrier to good practice which remained in existence was poor co-ordination with feeder schools. The first High School referred to in the extract catered for Year 6-9 pupils and shared the same campus as School E; the second was situated in a neighbouring suburb.

James: I'm reasonably happy that what is going on in the High School here is giving the knowledge both some basic knowledge to do with drugs, to do with alcohol, to do with smoking and also opportunities to explore some of the issues and to give them some skills.

Interviewer: Right.

James: But we have another feeder High School and they do have a slightly different way of approaching drug education. That is perhaps an area that we need to look at, in terms of what they have covered and the way that they actually cover it so when they come in they have some common experiences. That is something that we are looking at at the moment. The problems with moving from Key Stage 3 to Key stage 4 have been highlighted at County hall in all areas and that transfer of knowledge and skills in health education is obviously a key area.

In this quote the respondent is concerned with a quite different block to health-related communication.

James: From the work we do on smoking, we know that there's a real problem with some pupils switching off. If we use videos, people don't watch the videos – they just don't listen. Sometimes it's quite deliberate. They don't want to know, particularly if they're smoking.

Interviewer: A sort of psychological defense mechanism?

James: Yes. And a lot of students, 14, 15, 16, switch off because they think 'what's all the fuss about'. I don't smoke, I don't drink. But then in a years time, if their hormones have changed and if they've grown up a bit... Because they haven't really thought about things; because you've done it and delivered it – the same young men who were immature at 15/16 could end up getting involved with drugs. So their immaturity is a problem

This endorses the previously expressed view (see school C case study) that getting the scheduling of substance-related inputs 'right' is a very problematical for programme planners. It also supports the pupil data based impression that there is a need for drug-related input in *all* phases, as opposed to selective, phases of the school curriculum.

6.3 Summary of key findings

- The evidence showed that all the respondents were operating on the basis of assumptions about the best way to approach the delivery of drug education that accorded closely with the policy consensus of the time. Specifically they were persuaded about: the desirability of a life skills orientated model of approach; the importance of a school environment supportive to healthy choices and the need to take pupils' characteristics and social experiences into account.

- Lessons based around arguments about the risks and negative consequences of smoking, drug use and drinking were viewed as necessary to balance the ‘unhealthy’ influences that young people are exposed to. Some informants felt that ‘strong’ persuasive tactics had a legitimate place within programmes.
- The informants saw the benefits of reinforcing health education messages by making campuses smoke and drug-free, but highlighted a range of practical issues that made the implementation of smoking and drug-related policies problematical.
- Concern about the controversial nature of harm-reduction approaches (especially in respect to illegal practices) meant that materials geared to secondary prevention had a low profile within drug education programmes.
- Restricted time (linked to the relatively low status of non-academic subjects) and under-capacity in relation to skilled and confident delivery personnel were barriers to the implementation of good practice in drug education that applied in all cases. Underlying these problems, in the view of respondents, was the pressure and competing demands generated by the government’s drive to push up educational standards.
- Excessive caution about the type of drug-related interaction that is acceptable at the pupil-teacher interface appeared to be a threat to good practice in some instances. This caution was fuelled by a perceived need to respond to a ‘war on drugs’ policy agenda that appeared to undermine the scope for planners to sensitively tailor content to the concerns and informational needs of programme recipients.

- The availability of additional resources to support drug education delivery at LEA level was a helpful influence on the development of good practice on the ground. Ability to fully capitalize on this factor, however, was linked to institutional circumstances.
- Two positive features in this regard were a ‘balanced’ school ethos and the attachment of tangible forms of priority (time, resources) to subjects that support pupils’ personal, social and health (as opposed to academic) development.
- Also important was effective strategic leadership for the social subjects in the curriculum and a tradition of open communication and negotiated change management.

6.4 Discussion and conclusions

The findings presented in this chapter tie-in most closely with ‘bottom-up frameworks’ for understanding policy delivery (see chapter 2). Research designed to illuminate issues surrounding the implementation of urban and regional planning policies found that practitioners identified with a view of implementation as decision-making and ‘getting things done’. It then went on to suggest that choices and behaviour on the ground could frequently be accounted for on the basis of ‘resolution of conflicts between two sets of priorities and policy areas’ and/or an assessment of ‘what is feasible in the circumstances’ (Lewis and Flynn, 1979: 125). The present research focussed on a very different realm of social policy but generated findings that map onto these insights very closely.

The evidence highlighted a tension between the drug education policy agenda and the

wider, 'academic standards' agenda. Linking with this, it suggested that the greater importance attached to the second agenda by those high up in the power structure of the school meant that teachers interested in improving drug education practice had a limited range of options open to them for effecting change. In identifying money, politics and time as key constraints on scope for action in this sphere the informants in the five case study schools echoed findings obtained by Lewis and Flynn (1993) in the contrasting scenario of urban and regional planning. They were also similar to findings from an empirical study focussed on the implementation of school-based drug policies in three London boroughs (O' Connor et al, 1998). This study found that the translation of policies into effective working documents to inform school practice on a day to day basis was undermined by financial constraints on resources. It also stressed the low priority associated with drugs policies within school development plans and the inadequate allocation of training and time to plan, implement, co-ordinate and evaluate provision. Although the circumstances surrounding the implementation of drug policies were found to be generally unfavourable, the authors of this study did discover 'isolated examples of good practice' linked to 'individual organisational and personal commitment' O' Connor et al, 1998: 64). This finding relates closely to the present study where, in the case of School E in particular, drug education practices did seem to be moving in a positive direction. The organisational culture in this school appeared to be characterised by a combination of two particularly helpful features. The first was an educational ethos that attached value to the personal, social and health development of all pupils. The second was that staff on low rungs of the organisational hierarchy sensed that they were actually involved in the changes taking

place in relation to PSHE delivery and would be supported in their new roles. Concrete actions by senior management, most crucially provision of resources for curriculum development and training, appeared to be vital in contributing to this sense. Less tangibly, the Year Heads in charge of the PHSE programme in this school seemed to be able to draw on a bank of goodwill and trust despite the many national curriculum-linked demands for change and extra responsibility sapping the energy and enthusiasm of over-loaded teachers.

The bottom-up framework for analysing implementation supports the analysis that policies are products of compromise. It also argues that these same compromises in policy making continue to influence and shape its implementation (Barrett and Hill, 1984) – a thesis which links well with the findings from this study and is supported by the conclusion that

there is some lack of clarity in terms of the underpinning rationale for school drugs policies ... There are some mixed messages relating to the relative contribution of schools to the overall national drugs strategy.

O'Connor et al (1998): 64

The evidence from the five case studies suggests that the ambiguity surrounding the legitimacy of information geared to the avoidance of harm in the drug education provision at Key Stage 4, contributes to the gap between practice and what is known to work best in drug education. It does so by creating the perception that programmes should not operate from a position of pragmatism about the prevalence of smoking, drinking to the point of impairment and use of Class C drugs amongst school pupils on the brink of young adulthood. Instead, they should operate on the basis of the rather unrealistic hope that

information about health and legal risks and skills to resist peer pressure can provide inoculation against the 'threats' that substance use represents. The two operating positions have very different implications for the type and balance of messages that programmes will contain. On the basis of evidence presented in chapter 5, it is the avoidance-focussed (primary-prevention) scenario which most closely maps on to the contemporary practice of drug education in English schools and which helps to account for 15-16 year olds generally negative reactions to their experiences.

A final conclusion supported by the findings relates to an insight associated with the top-down framework for analysing policy implementation. Hood (1976) asserts policies can only be successfully implemented if they are based on a 'valid theory of cause and effect' and this raises the issue of whether the models of approach behind drug education intervention in the school-setting are based on logic and self-evident first principles. The life skills approach that is currently finding policy favour emphasises young people's need for information and skills to support 'healthy, informed choices' and is characterised by an underpinning 'deficit assumption' (Dorn and Murji, 1992: 15) and an orientation toward information and skills for resisting unwanted pressure. In the light of endorsement that the findings provide for existing critiques of the crude peer pressure thesis (e.g. Coggans and McKeller, 1994) it is possible to see that theoretical misunderstandings in this area play an important part in the explanation for drug education's limited 'scale of success' (Coggans, 1998).

CHAPTER SEVEN

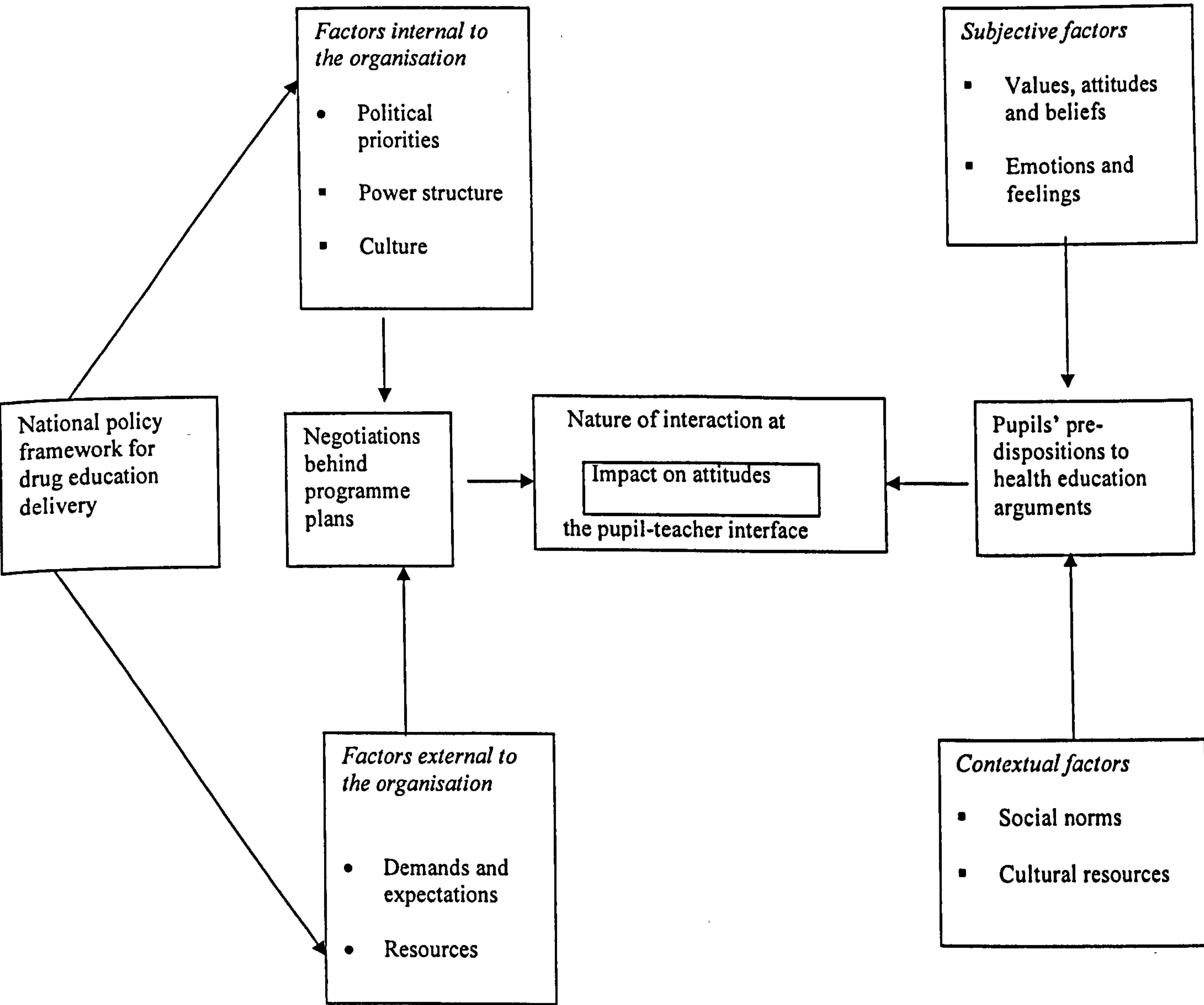
Theoretical insights

In light of the evidence from the primary research this chapter revises the provisional framework for analysing the drug education process that was set out in chapter 3. The way in which the empirical data both endorses and challenges the arguments and propositions embedded in the schema is evaluated and leads to modifications of the conceptual framework. The modified schema emphasises the interconnections between factors operating at different levels and dimensions of social reality. It also provides the anchorage for a theoretical analysis of two ‘ideal type’ implementation scenarios: the first favourable to the enhancement of delivery practices, the second prejudicial to the translation of drug education principles into action.

7.1 Background to the provisional schema

Before considering the impact of the empirical data on the provisional framework it is helpful to very briefly reconsider the conceptual background to the development of the provisional schema (see below for reproduction of figure 2.4 – originally featured in chapter 2, page 78). Theoretical frameworks for analysing the implementation stage of the policy process were a key source of influence on the conceptualisation of the delivery -

Figure 2.4 Provisional schema of influences on the processes of drug education in the schools setting



linked processes of programme planning, negotiation and implementation. The incorporation of *national policy framework for drug education delivery* reflected the emphasis placed on this matter in top-down models of implementation. Even more influential on the development of the schema were bottom-up frameworks which place

emphasis on the factors and processes (interactions) lying behind the choices of those involved in putting policy into effect at local level. They influenced the schema in three ways. First, they highlighted the *negotiations behind programme plans* as a potentially fruitful analytical focus. Second, they suggested that *factors internal* to the school such as *culture* and *power structure* were likely to be sources of influence on the outcome of these negotiations. Third, they suggested that the analysis needed to take into account *external factors* (i.e. factors such as social and political *demands and expectations* as well as level of *resources* in the educational system) which constitute the wider operating environment of schools.

The element at the centre of the schema, *nature of interaction at the pupil-teacher interface*, reflects the influence of the psychology of effective persuasive communication in understanding the mechanism by which drug education achieves (or fails to achieve) its intended influence and emphasises the importance of a good 'match' between message, medium, source and receiver characteristics. It also suggests that the outcome of the process reflects the nature of the interaction between message factors and the cognitive state of the recipient. In this sense persuasion depends on 'central processing' - the evaluation of arguments, assessments of conclusions and their integration within existing belief structures.

The right-hand side of the schema attempts to conceptualise the reception of drug education input by pupils. The inclusion of *pupils' pre-disposition to health education arguments* as an element reflects the direct relevance of the cognitive states for process

outcomes. *Values, attitudes and beliefs* are embedded in the schema as likely *subjective influences* on pre-dispositions – an assumption that derives from social cognition models of health behaviour. Such models propose that health-related action (and by extension response to health advice) reflect underlying health beliefs, outcome expectancies, perceptions of control and normative influences. The influence of *emotions and feelings* is neglected in such models but is emphasised in the schema on the basis of theoretical insights that highlight the way in which voluntary risk taking can fulfil important affective needs in relation to self and identity. The incorporation of *contextual factors* such as *social norms* and *cultural resources* in the schema derives from sociologically framed insights into cultural resistance to health education as well as the growing normalisation of adolescent recreational drug taking and its relevance for pupils' reception of drug education. School-based programmes of drug education are delivered in order to encourage 'healthy, informed' decisions about smoking, drinking and drug use, this *impact on attitudes* was incorporated into the schema on the basis that it would help in the evaluation of programme successes or failings.

7.2 Confirmed aspects of the provisional schema

Much continuity is apparent between the provisional schema above and the revised schema below set out on page 257. The following discussion offers a detailed analysis of the four main ways in which the empirical data provided support and endorsement for the initial conceptual framework.

1. The empirical data presented in the case study cameos in Chapter 6 (pages 220-241) confirmed that the nature and outcome of the negotiations behind programme plans is influenced by factors linked to the wider environment in which schools operate. The prioritisation of the academic standards agenda by the Government and related demands and expectations on schools, was widely perceived as a political factor that undermined the influence (and scope for manoeuvre) of institutional actors connected with the effort to implement good practice in drug education. Unrealistic social expectations about the ability of schools to combat the 'scourge' of drug misuse were also found to be relevant in this context. On the more positive side, sources of external support and funding for curriculum and staff development and aspects of the political initiative to reverse the decline in the fortunes of health education within the curriculum helped to enhance drug education practice.

2. The same evidence (see Chapter 6: 220-241) also supported the suggestion that the internal factors of institutional culture and politics have an important bearing on the negotiations behind programme plans. Two aspects of culture emerged as highly significant for the way in which enhancement-linked change and development was initiated at an institutional level. The first aspect was the school's educational ethos, specifically the extent to which this was underpinned by values supporting a strong and widely shared commitment to the personal, social and health development of pupils. The other important aspect concerned norms governing the internal monitoring and maintenance of curriculum standards. Of specific relevance in this connection was the

extent to which drug related delivery practices had evolved on the basis of feedback from/ negotiation with involved parties. Two linked aspects of institutional politics emerged as having a significant bearing on the prospects for the enhancement of drug education provision. The first issue was the presence (or absence) of actors in the Senior Management Team who were strongly allied to the interests of health education. Because of its implications for resources and political will the second issue concerned whether or not the quality development of drug education/health education/ PSHE provision was part of the school's strategic development plan.

3. Empirical data presented in the first section of Chapter 5 endorsed the claim that the subjective factors of values, attitudes, beliefs, feelings and emotions would influence personal reactions to drug education through the predisposition to health education arguments brought to the chalk-face. Specifically, it emerged that:
 - Pupils who believe substance use to be wrong were more favourably predisposed to health education arguments than those pupils who view the consumption of mood altering substances in a morally neutral manner. [See findings on the theme of *principled beliefs*, page 157].
 - Pupils with a strong subjective sense of the fragility of health were more motivated to receive health education arguments than pupils convinced their youth affords them protection from health threats. [See findings on the themes of *attitudes to health* and *critical incidents*, pages 151 and 154 respectively].

- Pupils who perceive that substance use could help them in relation to challenges associated with their self-identity (for example, the need for self-affirmation) were less receptive to health education arguments than pupils believing such behaviours would seriously prejudice their interests (for example, in respect to reputation in the community and/or family harmony). [See findings on the themes of *self identity*, page 161 and *family context and influence of friendship groups* page 168].
4. The empirical findings also confirmed the relevance of contextual factors for pre-dispositions to health education. Specifically, the findings suggested that:
- The lives of contemporary teenagers are characterised by identity and relationship-linked challenges and call for personal coping strategies. In many cases substance use is experienced as useful with regard to maintaining a functional work-life balance and this has an adverse effect on willingness to take up drug education messages [See findings on the theme of *the demands of social and school life*, page 165].
 - The growing normalisation of recreational substance notwithstanding, traditional cultural taboos against substance use continue to have salience for South Asian pupils (in particular female and/or Muslim ones) whilst they live under the roof of their parents. Lack of first hand experience of the ‘positives’ of substance use is a factor in the greater willingness of this group to accept the health education messages embedded in school-based programmes of drug education. [See findings on the theme of *cultural norms*, page 173].

- Under contemporary conditions teenage young people who decide they want to smoke, drink alcohol and/or try cannabis can readily obtain the substance they require. This environmental factor acts as an important barrier to the effective communication of the avoidance message. [See findings on the theme of *drug availability*, page 176].

7.3 Revisions to the provisional schema

In addition to providing endorsement for the arguments and suggestions in the original schema the empirical data served to challenge assumptions and pointed up problems with the conceptualisation of the relationships between elements. The adaptations introduced as a result of this process are brought together in the final version of the schema (Figure 7.1 page 257). Below, the rationale for the various changes is explained.

- 1) There was no empirical endorsement for the view that the *national policy framework for drug education delivery* needed separate incorporation into the schema based on the assumption that it would have a major bearing on the delivery blueprint formulated by school policy makers. Thus it was decided to de-emphasise this top-down factor by removing it as a core schema element. This is not meant to imply that policy levers and goals have no bearing on the negotiations behind programme plans at school level. Rather it takes account of the finding that current policy frameworks do not determine specific drug education programmes. They are the result of a gradual, evolutionary process and reflect the sum of the policy (and other) influences on them over the years.

Importantly the current framework surrounding the delivery of drug education (the demands it imposes, the resource context which determines capacity to respond) is still catered for in the schema by factors linked to the wider system (environment) of schools.

- 2) The evidence confirmed the link between pre-dispositions to health education arguments and the impact of programmes of drug education on pupils' attitudes (such as personal willingness to take health-related risks). At the same time it emphasized that it was pupil's *active* acceptance, selective uptake and/or rejection of the arguments presented to them that determined whether programmes had the desired impact on substance-related choices. These insights require that *take up of drug education messages* replaces *impact on attitudes* as the element providing indication of the success of interaction at the pupil-teacher interface.
- 3) The empirical data confirmed the influence of both *subjective* and *contextual factors* on pupils' *pre-disposition to health education arguments*. However, it challenged the implied gulf between these influences in the provisional schema by its depiction of unconnected boxes in the framework. In the adapted schema the conditioning influence of cultural and environmental factors on pupils' beliefs, feelings and concerns, as well as their response to drug education messages is conveyed using an approach emphasizing 'layers of influence'. This reflects realist ontological assumptions that the social world is constituted by multiple social domains including

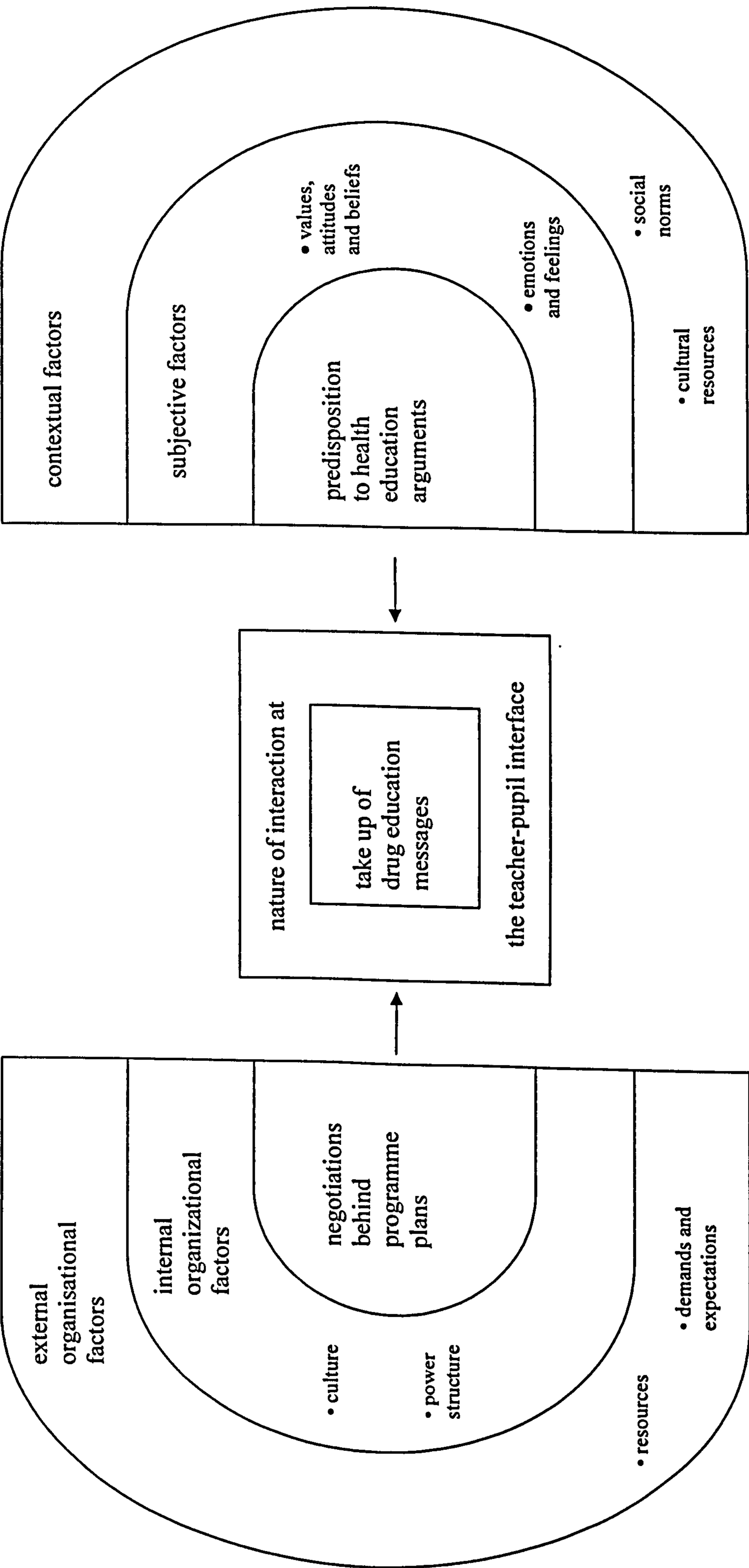
both lifeworld and system elements which inter-relate in complex and subtle ways (Layder, 1998). It also suggests that the diversity of social experience that pupils bring with them to the chalk face is a key issue that those responsible for drug education planning need to address when deciding on the mix of 'ingredients' (message and source factors) that will constitute programmes within given institutions.

- 4) Fieldwork evidence also poses questions about the implied gulf between internal and external organizational influences on the *negotiations behind programme plans*. This necessitates similar modification to the left-hand side of the schema on the basis that delivery-relevant factors located in the wider educational/ social system exert their influence through the activities, meanings, reasons and motives of those who handle drug education at school level.

7.4 The modified schema

The modified schema set out in Figure 7.1 (overleaf) embeds the key elements in the delivery and the reception of school-based programmes of drug education in layers of influence, one over another. This overlapping approach stands in contrast to the 'separate boxes' of the provisional schema and is intended to emphasize interconnection between factors operating at different levels and dimensions of social reality. The crucial need to draw attention to the interaction between subjective and objective elements stems from the

Figure 7.1 Modified schema of factors and processes underlying the implementation of drug education programmes in school setting



compelling evidence that the actions and reactions of drug education stakeholders (and the values, beliefs and emotions associated with these) are subtly molded by factors operating at the wider, societal level. This fits with the argument that it is best to understand macro and micro features as ‘intermingling with each other through the medium of social activity itself’ (Layder, 1993: 71). It also endorses the research focus on situated activity (negotiation in decision-making forums, communication at the chalk face) with key relevance to the nature and outcome of the drug education process in the school setting. An important proposition arising out of the modified schema is that one of the principles of good drug education discussed in the context of chapter 1 holds the key to a successful drug education process. This principle relates to the need for drug education to take account of ‘individual children and young people’s culture, beliefs, religious background and their social and family situation’ (Drug Education Forum, 1998: 2). Rhetorical support for this principle is easy; indeed, it is a hallmark of the drug education-related guidance that has been offered to schools in the last decade (DfE, 1995a; DfEE, 1998; DfES, 2004a; DfES, 2004b). However, the reality of the chalk face suggests that the issue of how best to respond to this is far from straightforward. Logistical problems mean that there is little scope to segment the audience to allow customized input - other than on the basis of chronological age – and this provides a dilemma for those responsible for programme planning. How best to cater for the social diversity that typically characterises Year groups? The evidence on pupils’ views presented in Chapter 5 suggests that the prospects of drug education making a health promoting difference to pupils are being undermined by a school-level failure to satisfactorily resolve this dilemma and implicates messages and

sources that lack wide credibility in this. The evidence in Chapter 6 confirms that, by necessity, drug education delivery is characterised by a broad-brush approach. It also highlights an interesting contrast between schools where action to enhance the quality of interaction at the teacher-pupil interface was in progress and schools where such action was being frustrated by the institutional view that such action was unfeasible or unworthy of investment.

The history of drug education provision in particular schools was crucial for the perceptions of the informants involved in the case-study interviews in so far as each instance was unique. This said the evidence based on these perceptions yielded insight into positive and negative factors impacting on planners' scope to develop practice in line with policy guidelines and recommendations. Below, these insights are incorporated into two 'ideal type' analytic scenarios. The first is favourable to the development of drug education programmes in positive (good practice) directions; the second is prejudicial.

7.5 Two contrasting analytical scenarios

This thesis set out to explore the processes underlying the delivery of school-based drug education programmes in order to account for factors that help and hinder the implementation of principles of good practice. The two scenarios below encapsulate the insights that have been generated by the research and highlight the complexity and inter-relatedness of the pertinent influences.

The scenario depicted in figure 7.2 highlights institutional factors supportive to the development of practice in line with the current state of knowledge about what works best in school-based drug education. Emphasis is placed on the operating positions of policy actors with different degrees and levels of influence in the power structure of the school as these represent the route through which contextual influence over programme delivery actions (based on blueprints) is mediated.

Figure 7.2 Scenario supportive of positive development in drug education provision

Subjective	Contextual	
	Institutional	Environmental
Powerful players take the view that initiatives to address the personal, social and health development of students have a strong claim on resources	Strong institutional commitment to the personal, social and health development of pupils	A national policy framework supportive of the development of health promotion work in schools
Co-ordinators feel confident that the programmes philosophy is widely endorsed	Tradition of inclusive management style leading to two-sided communication with all stakeholders	Official endorsement of educational model of drug education
Teachers involved with chalk face delivery feel supported	Adequate time and resources allocated to staff training and support (with opt outs possible if individuals are uncomfortable with drug education delivery)	Additional resources for support of drug education/prevention channelled into school via the LEA

In the scenario set out in Figure 7.3 attention is drawn to the way that the influence of factors prejudicial to development in good practice directions is mediated via institutional

actors with a subjective stake in the planning, negotiation and implementation of school-based programmes of drug education. The way in which external circumstances and internal institutional conditions interact to constrain progress endorses the key theme of this thesis.

Figure 7.3 Scenario prejudicial to quality enhancement in drug education provision

Subjective	Contextual	
	Institutional	Environmental
Powerful players take the view that the institution should prioritise initiatives to raise academic standards	Academic tradition/ethos Resource context (demand outstrips supply)	Dominant values in the educational system Top-down policy imperatives Resource context
Co-ordinators anxious to ensure that the programme can not be construed as condoning substance use	Tradition of not wishing to ignite controversial debates/ alienate those in the community with conservative views	Dominant 'war on drugs' policy perspective Social expectations about the role of schools in relation to 'social problems'
'Ordinary' teachers reluctant to embrace drug education delivery	Cultural resistance to (imposed) changes in practice Authoritarian management style	Traditions in the initial professional training of teachers (no preparation for health education delivery)

The core argument is that the process involved in the delivery of school-based programmes of drug education – and by extension their successes and failings – are subject to a complex array of influences reflective of a variegated and stratified social reality.

CHAPTER EIGHT

Conclusion

The purpose of this study was to explore the processes involved in the delivery of school-based programmes of drug education with the aim of identifying the factors helping or hindering the implementation of principles based on the current state of knowledge about ‘what works best’. It is now appropriate to reflect on the limitations as well as the theoretical and empirical implications of the study. To provide a context for the discussion a brief resume of the arguments and themes from the previous Chapters is provided. Next the methodological constraints on the study are examined, followed by a consideration of the various ways in which the research has added to knowledge. Finally the threads are drawn together in a series of recommendations based on the implications of the findings for policy, practice and further research.

8.1 Resume of previous chapters

Chapter 1 introduced the substantive topic of the thesis – drug education in the school setting. It provided a review of the background to, and policy framework surrounding, this key element of overall drug control strategy (Cm 2846, 1995; Cm 3945, 1998) in the period when the fieldwork for the thesis took place. A theme of the discussion was the importance of evaluation studies to the development of knowledge about what work best in drug education in the school setting and this provided a link to the next to the chapter.

Chapter 2 drew on the interpretivist and realist evaluation paradigms to establish the broad conceptual and methodological parameters to the research. It also reviewed concepts that might account for successes and failings in the implementation of good practice principles and incorporated them into a provisional schema. This schema then played a significant role in the formulation of the research questions.

Chapter 3 highlighted the compatibility of a mixed methodology research design with these research questions and provided detail about the methodological strategies and approaches that characterised the empirical approach. By explaining the intention to identify interesting patterns (linked first to reception and then to delivery) for subsequent qualitative follow up the chapter linked the quan/QUAL quan/QUAL sequential format to the interest in two key stakeholder groups. The first stakeholder group was pupils – the far from passive ‘targets’ for drug education programmes; the second was teachers with day-to-day and strategic responsibility for programme co-ordination and development.

Chapter 4 presented and analysed the findings from the study’s two quantitative phases. The survey of pupils highlighted patterns of difference in the impact of school-based health education on personal willingness to take risk within the population. The patterns had an ethnic dimension and reflected the comparatively low levels of smoking, drinking and drug use amongst South Asian female and/or Muslim pupils. In contrast the key finding associated with the data obtained from teachers was that variations in models of curriculum

organisation between schools did not translate into fundamental differences in drug education provision.

Chapter 5 presented and analysed findings that threw light on pupils' reactions to drug education input. First the evidence clarified the personal beliefs and interests associated with favourable and non-favourable pre-dispositions to drug education arguments and highlighted the relevance of the cultural and social factors that underpin them. Second the evidence pinpointed specific obstacles to receptivity with regard to the way the delivery of drug education was handled at school level.

Chapter 6 presented findings relating to influences on the negotiations that produce the blueprints for delivery at school level. The evidence established that programme *intentions* were compatible with the principles of good drug education being advocated and promoted at national level. It also highlighted institution-specific and wider, system-linked factors with both positive and negative impacts on programme co-ordinators' scope to effect movement in the direction of good practice.

Chapter 7 revised the provisional schema in the light of the empirical findings to endorse the principle that drug education should be sensitively tailored to the beliefs, interests and social experiences that young people bring to interaction at the chalk face. The Chapter culminated with an original analysis of two contrasting types of implementation scenarios:

one favourable to the development of good practice in drug education at school level, the other prejudicial to this process.

8.2 Recap of methodological limitations

Before considering the original contribution of this study and the implications for its findings for policy and practice it is appropriate to re-acknowledge the methodological limits of the research. (See Chapter 3 for detailed discussion of this matter). First, the findings do not reflect the perspective of pupils who were absent from school when the research was carried out. Consequently the evidence can not be safely generalized or transferred to the 15-16 year old section of the population as a whole. Excluded pupils and those in a regular pattern of non-attendance are recognised to be at increased risk of substance misuse. Any access they have to health education on the subject is liable to be via pupil referral units or other services focussed on socially excluded youth. In such situations the delivery-related recommendations put forward to address obstacles to receptivity may not be appropriate to the communication challenges associated with a highly disengaged population segment.

The insights with regard to influences on the implementation of good practice in schools came from two evidence sources, both of which had some limitations. The survey of drug education co-ordinators was, like all surveys, subject to bias. One issue was the non-response rate of 34% which, whilst respectable for a postal questionnaire, raises questions

about the validity of findings because there is the possibility that drug education provision in non-responding schools may differ significantly from provision in responding schools. The other issue concerns the level of confidence in the relevance of the survey findings beyond the East Midland context. This is enhanced by the fact that the survey's factual findings (levels of policy development, models of curriculum organisation) tallied closely with those of a survey carried out on a nationally representative sample of schools in a similar time frame and boosted confidence in the validity of the findings. Convergence of the opinion-based findings with qualitative findings on a similar theme (factors helping and hindering the development of good practice in drug education) within the case studies performed a similar function.

The second key source of insight into implementation-relevant factors was the interviews conducted within the case study schools. The case study approach is most vulnerable to criticism in relation to the credibility of its generalizations. It was, therefore, reassuring that the perspectives of the informants in the five case study schools on factors helpful or detrimental to the implementation of sound drug education policies converged with opinions expressed by survey respondents. This acknowledged, it is important to recognise that the findings are likely to transfer best to parts of the country that operate a model of educational provision comparable to that used by Leicestershire (the education authority which supplied all the case study schools). This model is characterised by High School education for pupils in Years 7, 8, 9 followed by transfer to a separate Upper School for

pupils in Years 10-11. Such a model poses particular challenges in terms of the effective co-ordination of pupils' drug education entitlement between Key Stage 3 and KS 4.

The nature of interviews means it is impossible to rule out the possibility that the case-study informants were putting their personal actions (and non-actions) in the best possible light. This has some inevitable implications for the levels of trust that can be invested in the findings. Concern is offset, however, by informants' shared understanding about the educational and wider societal backdrop against which they were operating as well as by the previously mentioned convergence with questionnaire findings. A combination of resource constraints and lack of opportunity (access) precluded the possibility of interviews with a wider range of informants. The same considerations also ruled out the possibility of participant observation of drug education lessons. These strategies would have provided additional data to enrich the study and - had the findings converged – would have further increased confidence in the validity of the findings even further.

8.3 Contribution to knowledge

The research has made an original contribution to knowledge in three main ways. The first relates to the fact that the methodological approach adopted differed from the approach that has traditionally been usually used to study the social intervention of school-based drug education. The second relates to the analytical framework developed through an

iterative dialogue between hitherto unrelated empirical data and theoretical arguments. The third is the study's contribution in terms of findings based on the empirical data.

An innovative methodological approach

As previously discussed (chapter 2) studies of health education intervention in school settings have, traditionally, been characterised by the outcome focus of the rational-technical evaluation model. Process evaluations are comparatively rare and those that have been undertaken have tended to focus on specific and innovative projects. The little research that has been undertaken to open up the black box of routine provision tends to fall into one of three camps. Descriptive research focussed on what pupils say they get/want from drug education; official monitoring exercises to assess lessons against (top-down supplied) quality criteria, and research designed to explore and analyse the delivery context which exists in schools. The methodological uniqueness associated with this study was its dual focus on delivery and reception (specifically pupils' interpretations of and reactions to programme input) and its attention to the way that contextual factors constrain and condition delivery-related actions and reception-related reactions.

The study was influenced by ideas and assumptions set forth by Pawson and Tilley (1997) in their articulation of a realist evaluation paradigm developed in tandem with empirical research focussed on interventions to tackle problems of crime (Tilley, 1993; Tilley, 1993). The application of realist conceptualisations and principles to the evaluation of interventions to tackle public health problems is not unique (Kaneko, 1999). It is, however,

rare enough to warrant the claim that this research helps to consolidate the place of realist evaluation approach within the methodological 'tool box' of health promotion evaluators.

A distinctive analysis of the dynamic of influences of the drug education process

The approach to theory development that has characterised this study is based on the principle that pre-existing concepts, constructs and theoretical insights have an invaluable contribution to make to the research and analysis of chosen problems. The provisional schema developed to guide the data collection and data interpretation embodied this principle and brought together a range of pertinent but previously un-combined theoretical resources to identify, and relate elements that could potentially help to make sense of the drug education process. The adapted schema that emerged from the interaction between the empirical data and the provisional conceptual framework is innovative and anchors an original analysis of factors helping and hindering the implementation of good practice principles in drug education. The main value in this analysis is that it brings to attention the challenges faced by policy actors with responsibility for the development of drug education at school level. This offsets the possibility that quality failings in drug education are presented in the light of a failure of schools to understand how drug education should ideally be tackled. By illuminating the background to the compromises behind delivery plans it adds a new perspective, on the basis of data gathered from pupils, to the negative picture of provision. Arguably, this new perspective shows how teachers with responsibility for the implementation of drug education programmes are trying their best,

in less than ideal circumstances, to structure programme-based opportunities for beneficial exchange of information and ideas.

New empirical insights

The findings make a constructive contribution to knowledge in the health education field in so far as they highlight the groups of 15-16 year old who consider they derive benefit from school-based programmes of drug education. In stark drug prevention terms, they are the ones who need it least in the sense that they are in social circumstances and/or are motivated by personal beliefs and interests that have already led to the development of negative attitudes towards substance-related risk taking. The pupils who are dismissive or neutral about the benefits derived are, in contrast, the ones with potentially most to gain from a drug prevention perspective because there are *degrees of risk* that they are prepared to tolerate. Such pupils – and it is worth reiterating the finding in this research that they were in a distinct majority - provide a challenge to the planners of drug education input. They are likely to be selective in their uptake of drug education messages, and *inclined* to only engage with arguments that are perceived to accord with their pre-existing beliefs and/or relate to the concerns and interests that motivate them.

Linking with this point the findings identify characteristics of delivery that hinder fruitful drug-related interaction because they lend themselves to negative interpretation by 15-16 year olds lacking in ‘natural’ affinity with either a selection or all of the arguments embedded in school-based programmes of drug. This can be seen as another modest shift

forward in understanding by highlighting the need for co-ordinators to give consideration to the way that different sections of the audience are liable to construe the programme on offer. Co-ordinators must also use all the influence at their disposal to bring about change in practices that constitute a barrier to reception of the arguments.

Finally the findings cast new light on the circumstances surrounding the delivery of school-based programmes of drug education. These highlight some 'classic' implementation constraints in the education and wider social system - most notably time, money and unrealistic expectations. However, this is balanced with evidence drawing attention to the way policy actors on the ground can make progress in a good practice direction in the face of these obstacles. Simultaneously the findings draw attention to helpful changes introduced into the implementation context since 1995 – the year when drug education was first formally adopted as a key element of national drug control strategy. But, again, is balanced by evidence drawing attention to cultural and political circumstances at institutional level that militate against the potential in the new opportunities being realised.

8.4 Implications of the findings and associated recommendations

Bearing in mind the limitations associated with key findings it is now possible to draw out implications for policy, practice and future research. In each instance brief consideration of

the significance of specific evidence leads to a recommendation aimed at supporting the future enhancement of drug education intervention in the school setting

Policy recommendations

The findings confirmed that top-down policy intervention (guidelines setting out expectations, statutory frameworks linked to inspection regimes, money to support training, input from LEA advisors) *can* contribute to an improvement in the quality of drug education provision within the school sector. At the same time there was evidence to show that the existing mechanisms employed to bring about change do not necessarily have the desired effects (and may even have un-anticipated negative ones). An institutional ethos that valued the academic development of pupils far more highly than other types of development (personal, social, health) was highlighted as a significant obstacle to action to improve the student experience and this leads to the recommendation:

- *National government, through strategic partnerships at local level, should act to promote the willingness and capacity of schools to maximise their contribution to the personal, social and health development of pupils.*

It is important to note that the National Healthy Schools Standard initiative (DfEE, 1999), a policy development that builds on the Healthy Schools initiative (described in chapter 1) represents an initiative in tune with this recommendation. Jointly funded by the Department for Education and Skills (DfES) and the Department of Health (DH) the standard has the overall aim of helping schools to become healthier. It does this partly by

supporting schools to introduce and embed the incremental changes that characterise the standard via a nationally accredited local awards scheme. Partly it does this by managing two continuing professional development programmes (one for teachers of PSHE, the other for school nurses) aimed to build delivery capacity (DfEE, 1999). The voluntary nature of this scheme places a question mark over the extent to which it can embed acceptance of the importance of investment in pupils' health throughout the school system. That said the targets set for achievement of National Healthy School Standard, and their incorporation into performance management frameworks, are likely to galvanise recruitment into the scheme and may eventually mean that health promoting values take firmer hold in institutions where the educational ethos is currently very narrow. Such a cultural shift will take time and sustained effort, particularly in an educational climate dominated by academic league tables. The discontinuation of Standards Fund 204, money ring-fenced by the DfES to pay for a School Drug Advisor in every LEA, in March 2004 represents a potential threat to the future development of good practice in schools. In light of this it is recommended that:

The DfES and DH, in conjunction with local strategic partnerships, develop a strategy for incorporating the National Healthy School Standards initiative into the mainstream of partnership working on health improvement/ drug prevention at local level.

The official 'line' on the legitimacy of a harm reduction focus within the programmes of drug education provided for adolescent pupils is rather unclear and there was some evidence that this was having a negative effect on the implementation of good practice at school level. Confusion on this potentially controversial issue was most apparent in

institutional contexts where co-ordinators were operating from a position of caution because they felt vulnerable that materials and teaching activities not explicitly geared to the need-for-avoidance message, could be construed as implying that the school condoned substance use. A lack of open communication with parents regarding the aims and purposes of drug education provision appeared to fuel the perception and this has implications for policy action at school-level that will be picked up in a later recommendation. Also relevant, however, was the impression that the communication of information aimed at equipping young substance users to do so more safely had not received official endorsement as a legitimate role for drug education within the school setting. This leads to the policy recommendation that:

- *National government conveys a clearer message to schools regarding the acceptability of harm-reduction approaches.*

Interestingly, the latest guidance to schools and pupil referral units (DfES 2004b) suggests that the need for a greater level of clarity has now been recognised at policy level. This revision of the authoritative guidance first issued to coincide with the launch of the Major Government's anti-drug strategy (DfE, 1995a in the context of Cm 2846, 1995) draws the attention of schools to older pupils' vulnerability to harm from binge drinking and states:

The aim of alcohol education should be to reduce the risks associated with pupils' own and others drinking. A harm reduction approach accepts that people drink and seeks to enhance pupils' abilities to identify and deal with risks situations. It should not suggest that alcohol misuse is acceptable. Rather it should allow children and young people to make safe and healthy choices.

DfES, 2004b

The need to highlight the links between drinking, personal responsibility and sexual behaviour is also emphasised. In the case of smoking it clarifies that ‘while the emphasis should be on providing information and developing attitudes and skills that will help pupils not take up smoking, ‘the question of smoking cessation should be addressed’. In the case of ‘other ‘drugs of significance’ (cannabis, volatile substances, Class A drugs) no endorsement of a harm reduction focus is provided. The need to tackle ambiguity in this area is particularly pressing in the light of the political pressures on the current Government to take a tough stance on drugs.

The evidence suggested that the delivery of school-based policies on drug-related incidents took place against the backdrop of a clear legal position on the possession of prohibited drugs for the purposes of personal use and/or dealing. However, in contrast there was some evidence that the legalities surrounding the teaching of sensitive elements of school-based programmes of health education were less clear-cut. Interestingly the revised guidelines previously referred to (DfES, 2004b), endorse the strategy devised by one informant to ensure that the delivery team did not become privy to information that could have required them to initiate some intervention. Thus, under a heading of ground rules, they highlight the desirability of:

‘A group agreement, established through discussion and negotiations with pupils (that) fosters mutual respect and an environment in which pupils are ready to listen to and discuss other’s opinions. One of the rules should establish that it is not appropriate for pupils or teachers to disclose or discuss their personal or family drug use.’

DfES 2004: 20

This approach has the important advantage of protecting all parties from negative consequences that they might not anticipate in the immediacy of discussion. However, it also provides an obstacle to the achievement of the ‘full frank’ discussion that the pupils in this study indicated they wanted (and the informants said they hoped to provide) and intensifies the problem of programmes being planned on the basis of intelligent guesswork. (Or, as some pupils seemed to believe, unintelligent guesswork in the sense that it underestimated the extent to which drugs impinge on the lives of young people in contemporary society.) Consequently it is recommended that:

- *The national and European-level surveys that currently inform national strategy in the areas of drug prevention and health promotion continue on an annual basis. Linked with this is the recommendation that key findings from the most up-to-date reports available (ECAS 2002; Boreham and Shaw, 2002; Bellis et al 2003;) are produced in a teacher-friendly format and widely disseminated with a view to them informing programme planning-linked decisions at school level.*
- *That local Drug Action Teams follow the same recommendation with the intelligence that they gather to inform the development and periodic revision of their local young people and substance use plans*

This thesis has been based on the assumption that programmes of school-based drug have a contribution, albeit a relatively minor one, to make to the achievement of policy goals in the areas of smoking, alcohol and illegal drug control. The evidence presented in

its pages has highlighted the need to understand young people's risk-taking in its broad social context and gives rise to a final recommendation about the need for:

Policy makers to act on the basis of a realistic appraisal of what school-based programmes can be expected to achieve in the face of the social and economic forces that undermine its attempts to influence young people's drug-choices in 'healthy' directions.

Implications for practice

The evidence highlighted a number of delivery issues that undermined the prospects of drug education arguments being taken up by pupils because of their negative impact on the process involved with programme reception. The findings connect with principles distilled from a social-psychological research in the field of persuasion and lead to the conclusion that the limited impact of programmes of drug education reflects practical obstacles to a sensitive response to the individuality and social diversity that characterises Year groups. The discussion below is structured in terms of the implications for the level and timing of exposure to messages, the type of *message* incorporated in the programme and the qualities and skills of the personnel that act as the *source* of the messages. This emphasises the continuity of the findings with research that, to date in the drug prevention context, has had most influence over the planning of media-based programmes and campaigns.

Curriculum vehicle: From a pupil perspective, the scheduling of first-time coverage of drugs of significance - notably tobacco, alcohol, cannabis - within drug education programmes occurs too late to have an influence on the initiation decisions of the trend-setters and/or boldest members of the Year. This omission of well-judged exposure is then compounded, in some pupils' experience, by the profile of health education in the curriculum dipping to a low, or non-existent, point at the very time (Years 10 and 11) when choices surrounding drugs stop being hypothetical due to ready access and increasing temptation. Corroboration for this was provided in a minority of the 12 schools supplying focus group members and interviewees discussion with the teachers arranging access. The impression that the time devoted to discussion on important drug-related issues was inadequate to support their full complexity was more widespread and suggests an important conclusion. Namely, that an inadequate level of exposure to the arguments diminishes the prospects of drug education effectively countering the commercial and other forces exerting influence over the 'starting, switching, slowing and stopping' decisions (Parker, Aldridge and Measham, 1998) so characteristic of this phase of pupils' development. Two linked recommendations for practice stem from these insights.

- *The first health education handling of drugs of significance should come earlier in the phasing (spiral curriculum) of school-based programmes of drug education than is currently usual.*

- *Drug education programmes should receive an allocation of (timetable) time that is commensurate with the achievement of their identified goals and enables them to reach pupils at all phases in their compulsory education.*

Types of message: The perception that drug education programmes incorporate biased and/or over-exaggerated claims about the dangers associated with drug use was found to be widespread amongst pupils lacking a favourable pre-disposition to drug education arguments. Whilst the ‘facts’ of the matter may be open to dispute this does not alter the damaging impact of the *impression* on the willingness of this section of the audience to engage constructively with the information and ideas on offer. The data generated insight into two perceptions contributing to this impression. The first was the tendency for programmes to rely on one-sided messages that incorporated little acknowledgement of the positive dimensions of smoking, drinking and/or drug use. The second was the tendency for programmes to promote the idea that cannabis is a dangerous drug without presenting sufficient backing evidence to counter pupils impressions of it as a substance on a par with (or even below) alcohol in terms of its ill effects for health. Decisions to mainly rely on arguments that support the case for the dangers and negative consequences of drug use and to send unambiguous messages (drugs are ‘bad’: avoidance of them is good) are understandable from a narrowly focussed public health or legality point of view. On the evidence, however, such decisions misjudge the sophistication of their audience with regard to communication on the topic of drugs and, in the process, provide ammunition against arguments with potential to challenge beliefs based on lack of information/

misinformation. (That some young people in the study considered drugs that are smoked or taken by mouth are 'safer' than those which are injected provides an example of an erroneous belief that health education arguments – if received and accepted - have the potential to modify.) The following recommendations follow on from this analysis:

- *The drug education provided for older pupils should rely on two-sided messages (i.e. communications that balance information and ideas emphasising the risks and negative consequences of drug use with realistic acknowledgement that there are positives associated with drug use).*
- *The drug education provided for older pupils should draw greater distinction (backed up by a convincing level of evidence) between the risks associated with different types of drug, different modes of drug use and different types of drug using context.*

The source: In the assessment of pupils looking back on their personal experiences of school-based drug education the value and benefit of the enterprise was heavily dependent on the teacher delivering it. Frequently, the evidence suggested, this teacher had not been 'up to the job'. Criticisms about teachers' lack of knowledge and expertise in and about drugs, especially the social realities of drug use, were common and were implicated in the problem of low perceived source credibility. Also implicated in this, via the trustworthiness dimension of credibility, were suspicions that teachers were trying to manipulate their choices by exposing them to biased opinions. Such suspicions were

associated with teachers considered to be poor at facilitating open, two-way discussions. The impression conveyed by pupils was that encounters with such teachers were far from unusual. This impression points to a capacity-problem with regard to health education delivery skills within the teaching workforce. By contrast with their negative perceptions of teachers as deliverers of drug education, pupils tended to rate outside contributors to their programme highly. Those able to bring relevant personal experience alive in a vivid and absorbing way were particularly appreciated. The tendency for staff involved in drug education delivery to command low credibility in the eyes of pupils has implications for the status of the programme by eroding the idea that health education is a serious subject, worthy of pupils' attention. Given the cost implication of capacity building to support the effective delivery of drug education and the fact that teachers who consider themselves genuinely unsuited to the delivery of 'sensitive' aspects of PSHE are unlikely to provide pupils with a positive experience, it is recommended that:

- *Schools assign a team of specialist teachers to the delivery of sensitive aspects of the PHSE programme and facilitate the continuing professional development of that team making full use of local opportunities such as those provided under the auspices of the NHSS.*
- *External contributors who have special expertise to bring to the programmes, and/or who can relate to pupils in different and productive way, are used to enrich the experience of pupils.*

The policy implications of findings highlighting the helpful contribution of a health promoting school ethos to the implementation of good drug education practice have already been drawn out. Here the emphasis is on the importance of effective communication aimed at winning wide ownership of the drug education programme. The evidence suggested that:

- Pupils' tended to be oblivious to the fact they were participating in programmes underpinned by a 'healthy, informed choice' model.
- A proportion of delivery teachers (drawn from the ranks of the 'press-ganged') erroneously believed that the purpose of drug education was to supply ready-made 'right' choices.
- Some parents/ sections of the media expected schools to act as the front-line in a war against the 'evil of drugs'. Two issues were found to compound this problem. First, the use of genuine consultation as a mechanism for increasing the levels of ownership was not widespread. Rather, it was restricted to institutional contexts in which the style of senior management was an inclusive one, characterised by open communication with all relevant parties. Second, when such exercises took place their value tended to be undermined by apathy and/or reluctance to be involved in the process.

All this leads to the recommendation that:

- *Schools, backed by their Local Education Authorities, prioritise the development of imaginative strategies that will enable them to communicate the purpose and approaches of the drug education programme to stakeholders and enable them to influence action plans.*

Implications for research

The evidence highlighted the value pupils tended to place on their freedom to make their own lifestyle choices. At the same time it emphasised the way in which the reasoning behind the pupils substance related intentions and practices was influenced by their ethical concerns. (Thought-provokingly the research participants often expressed the view that the use of alcohol to get high was ‘worse’ than the use of cannabis because it tended to lead to drunkenness – a state that could have a bad effect on other people, via violence and other forms of anti-social behaviour). School-based PSHE and Citizenship programmes provide an obvious vehicle for the development of ethical reasoning skills and creates a need for teaching materials that can support understanding of ethical concepts and principles and facilitate their application in meaningful scenario situations. To inform the development of such materials (a precursor to research focussed on the effectiveness of projects employing such materials within the health education context) it is recommended that:

- *Research is carried out to explore young people’s ethical perspectives on issues related to drugs and drug use in society*

The conceptualisation of the reception of drug education in this thesis has been based on the theoretical assumption that a young person's willingness to take up drug education is influenced by the subjective predisposition to health education arguments they bring with them to lessons. There has been an emphasis on values, attitudes and beliefs, and the social experiences and contexts that shape and influence these – perhaps to the neglect of affective factors with a bearing on young people's receptivity to drug education. The emotional component of negative reactions to messages geared to 'healthy' choices has not been entirely overlooked. The findings highlighted the way that the perception that substance use serves a function in relation to stress relief and self image and identity has a negative impact on willingness to take up and act on drug education messages. Deeper exploration of the relationship between emotional state and receptivity could provide valuable insights with implications for the policy and practice of school-based drug education. It is therefore recommended that:

- *Research is carried out to explore young people's perceptions about the role of substance use in relation to their emotional needs.*

This study addressed the research problem of the implementation of good practice in drug education in the aftermath of an education circular (DfE, 1995). Revised guidance setting out new expectations (particularly in relation to the 'good management of drugs within the school community') has recently been made available to schools (DfES, 2004) and the

aftermath of this would provide a good backdrop to a study aimed at revisiting the research problem/issues. Particularly interesting would be investigation of whether factors identified as having a positive and negative impact on the scope of drug education to make quality improvements, have changed/evolved. On one hand, re-employment of the same study design in the same area would provide the basis for illuminating time-sequence analysis, on the other hand there would be advantages attached to a revised study design. This might include a new selection of case studies (for example epitomising different levels of involvement with the National Healthy School Standard initiative); providing opportunities to explore provision at Key Stage 3 as well as KS4, and/or a wider use of strategies and informants. This leads to the recommendation that:

- *Further research is undertaken to explore the implementation of principles of good practice in drug education within the policy framework that has evolved under New Labour and build on and further develop the analytical framework presented in Chapter 7.*

APPENDICES

- Appendix 1 The principles of Drug Education in Schools (Extract from
ACMD (1993) Drug Education in Schools: the Need for a
New Impetus. HMSO)
- Appendix 2 Key Principles of Drug Education (Taken from DfES
(2004) National Healthy School Standard – Drug Education
Health Development Agency)
- Appendix 3 Profile of 12 survey schools
- Appendix 4 Research Instruments
- 4a) Health-related attitudes and behaviour questionnaire
 - 4b) Focus Group Schedule
 - 4c) Interview Administration Procedure
 - 4d) Survey of drug education co-ordinators: questionnaire
 - 4e) Interview schedule for use in case study schools

Appendix 1

The Principles of Drug Education in Schools

[As featured in Circular 4/95 Drug Prevention in Schools (DfE, 1995a)]

a. AIM

- The aim of drug education is to enable pupils to make healthy and informed choices

b. OBJECTIVES

i. Increasing knowledge, changing attitudes and enhancing skills

- To provide opportunities for pupils to acquire knowledge and understanding about the dangers of drug misuse
- To provide opportunities for pupils to be equipped with the knowledge, attitudes and skills they need to avoid the misuse of drugs and to help reduce school problems associated with drug misuse where locally appropriate

ii. Behaviour

- To minimise the number of young people who ever engage in drug misuse
- To delay the age of onset of first use for those who do experiment at any time
- To minimise the proportion of users who adopt particularly dangerous forms of misuse
- To persuade those who are experimenting with or misusing drugs to stop
- To enable any pupils who are misusing drugs or who have concerns about the misuse of drugs to seek help

iii. Citizenship

- To increase knowledge of social and personal issues relating to drugs in line with the National Curriculum

- To enhance young people's capacity to contribute to school policies on drug misuse and wider community matters
- To enhance young people's decision-making skills more generally, using drug education as a vehicle
- To enhance later parenting skills in relation to prevention of drug misuse when pupils reach adulthood

c. CONTEXT

- Drug education should be provided in the broader context of the teaching of health and personal and social education as a part of a pupil's life skills and preparation for adulthood
- It should aim to involve the parents and encourage them to take an interest
- It should be delivered in the context of the school as part of the community
- It should take account of the age, sex and cultural/social background of the pupils at which it is targeted
- It should take account of the local circumstances and culture of the community
- It should provide factual and accurate information backed up with consistent advice
- It should aim to teach pupils the necessary social and personal skills described in (b)(i) above

d. CONTENT, METHODS AND ORGANIZATION

- It should be delivered in a clear and honest manner that informs without encouraging drug misuse
- It should encourage active pupil participation backed up with adequate teacher supervision

- It should be provided at regular intervals throughout the school career so as to maximise its effectiveness
- It should be provided by teachers and other professionals with specific training in the requirements of drug education and issues relating to drug misuse
- It should be evaluated
- It should be backed up with access to advice or help for pupils with problems or concerns.

Original source: ACMD Report, "Drug Education in Schools: the Need for a New Impetus", HMSO 1993)

Appendix 2

Key principles for drug education

- Create a supportive school ethos, culture, environment and management structure
- Start drug education in primary school. It may also be appropriate to begin exploring the role of medicines with young children in foundation years
- Use effective teaching strategies such as role play and discussion
- Use children's and young people's existing knowledge, experience and perceptions of drug issues as a starting point
- Ensure drug education progresses as pupils move up through the key stages
- Information and approaches take account of gender, social and cultural issues, and local trends
- The range of substances is covered including medicines, alcohol, tobacco, solvents and illegal drugs
- Make links between drugs and other related issues, such as sexual health
- Content is age appropriate and includes skills development and attitude exploration
- Children and young people participate in drug education planning, teaching and evaluation

- Drug education is delivered as part of PSHE and Citizenship
- Teachers are trained and confident
- Involve and educate parents/carers to support school activities both in school and at home
- Assess pupil's learning and progress
- Monitor and evaluate teaching strategies and assess future need
- Outside agencies/individuals and schools agree roles and responsibilities and agencies' input is planned as part of a comprehensive drug education programme
- Strong links exist between the school and the community as a whole
- Students know where and how to access help and support

Taken from DfES (2004) *National Healthy School Standard – Drug Education* Health Development Agency –www.wiredforhealth.gov.uk

Appendix 3

Profile of the 12 survey schools

School 1

Location of school/college: inner city

Catchment area for school: urban
predominantly working class (75% on fathers job)
ethnic origins = 90% South Asian
religion = 50% Moslem, 25% Hindu, 15% Sikh

Academic attainment level of school (1995-1996 figures)
27.8% pupils achieve 5 or more grades A-C at GCSE

School 2

Location of school/college: market town

Catchment area for school: evenly split between rural villages and market town
50% middle class, 50% working class (fathers job)
ethnic origins = virtually 100% White

*Academic attainment level of school (1995-1996 figures)**
52.7% pupils achieve 5 or more grades A-C at GCSE

School 3

Location of school/college: borders of an outer city council estate

Catchment area for school: council estate
working class or unemployed
virtually 100% White

Academic attainment level of school (1995-1996 figures)
6.1% of pupils achieve 5 or more grades A-C at GCSE

* Proportion in local area as a whole = 39.9%

School 4

Location of school/college: industrial town

Catchment area for school: rural/ industrial town
predominantly working class (70% on basis fathers job)
virtually 100% White.

Academic attainment level of school:
31.6% of pupils achieve 5 or more grades A-C at GCSE

School 5

Location of school/college: market town

Catchment area for school: equally split between rural villages and market town
mainly (60%) middle class (on fathers job)
ethnic origins = virtually 100% White class

Academic attainment level of school:
45.6% of pupils achieve 5 or more grades A-C at GCSE

School 6

Location of school/college: inner city

Catchment area for school: urban
predominantly working class (74 % on fathers job)
ethnic origins = 75% South Asian 20% Afro Caribbean

Academic attainment level of school:
33 % achieve 5 or more grades A-C at GCSE

School 7

Location of college: village now surrounded by several large private housing estates

Catchment area for school: equally split between rural villages and large town
equal split between middle and working class pupils
ethnic origins = virtually all White (a v.few Bangladeshi)

Academic attainment level of school:
44% pupils achieve 5 or more grade A-C at GCSE

School 8

Location of school/college: outskirts of a market town

Catchment area for school: 2/3rds rural/ 1/3 market town
predominantly (55%) middle class
ethnic origins = virtually 100% White

Academic attainment level of school:
48 % pupils achieve 5 or more grades A-C at GCSE

School 9

Location of school/college: village, now become part of urban sprawl

Catchment area for school: rural/suburban
66% middle class, 33% working class
ethnic origins = 75% White, 25% Asian
religion of Asian pupils = predominantly Hindu

Academic attainment level of school:
37.2% of pupils achieve 5 or more grades A-C at GCSE

School 10

Location of school/college: city centre

Catchment area for school: urban, mainly council estates.
predominantly (80%) working class + unemployed
ethnic origins 75% White, 25% South Asian
majority of the Asian pupils = Hindu

Academic attainment level of school:
9.7% of pupils achieve 5 or more grades A-C at GCSE

School 11

Location of school/college: city centre

Catchment area for school: urban/suburban - males
40% middle class / 60% working class (fathers job)
ethnic origins = 85% White, 15% South Asian
majority of Asian pupils = Hindu

Academic attainment level of school:
42% pupils achieve 5 or more grades A-C at GCSE

School 12

Location of school/college: city

Catchment area for school: urban/suburban
40% middle class / 60% working class (fathers job)
ethnic origins = 70% White, 30% South Asian
majority of Asian pupils = Moslem

Academic attainment level of school:
49% of pupils achieve 5 or more grades A-C at GCSE

Health-Related Attitudes and Behaviour

0 [] 1 [] 2 [] 3 [] 4 [] 5 [] 6 [] 7 [] 8 [] 9 []

Office Use Only

0 [] 1 [] 2 [] 3 [] 4 [] 5 [] 6 [] 7 [] 8 [] 9 []

0 [] 1 [] 2 [] 3 [] 4 [] 5 [] 6 [] 7 [] 8 [] 9 []

0 [] 1 [] 2 [] 3 [] 4 [] 5 [] 6 [] 7 [] 8 [] 9 []

0 [] 1 [] 2 [] 3 [] 4 [] 5 [] 6 [] 7 [] 8 [] 9 []

Section 1

1 Which ONE of the following categories best describes yourself?

- | | | | |
|------------------------------------|-----|---|-----|
| never smoked | [] | smoke less than 6 cigarettes a week | [] |
| tried smoking, but never liked it | [] | smoke between 6 to 20 cigarettes a week | [] |
| used to smoke but have given it up | [] | smoke more than 20 cigarettes a week | [] |

2 Would you agree or disagree with the following statements?

- | Smoking | Agree | Disagree | Don't know |
|-------------------------------------|-------|----------|------------|
| ... is enjoyable | [] | [] | [] |
| ... is a waste of money | [] | [] | [] |
| ... helps me feel part of the group | [] | [] | [] |
| ... is against my religious beliefs | [] | [] | [] |
| ... is OK in moderation | [] | [] | [] |
| ... helps me relax | [] | [] | [] |
| ... is a danger to my health | [] | [] | [] |
| ... is part of being grown up | [] | [] | [] |
| ... makes me feel more confident | [] | [] | [] |
| ... makes me feel ill | [] | [] | [] |

3 Which ONE of the following categories best describes yourself?

- | | | | |
|---------------------------------------|-----|------------------------------------|-----|
| never drink alcoholic drinks | [] | drink two or three times a week | [] |
| only drink on special occasions | [] | drink more than three times a week | [] |
| drink once a week or once a fortnight | [] | | |

4 Would you agree or disagree with the following statements?

- | Drinking alcoholic drinks | Agree | Disagree | Don't know |
|-------------------------------------|-------|----------|------------|
| ... is enjoyable | [] | [] | [] |
| ... is a waste of money | [] | [] | [] |
| ... helps me feel part of the group | [] | [] | [] |
| ... is against my religious beliefs | [] | [] | [] |
| ... is OK in moderation | [] | [] | [] |
| ... helps me relax | [] | [] | [] |
| ... is a danger to my health | [] | [] | [] |
| ... is part of being grown up | [] | [] | [] |
| ... makes me feel more confident | [] | [] | [] |
| ... makes me feel ill | [] | [] | [] |

5 How many times in the last month have you had an alcoholic drink in the following contexts?

- | | none | once | twice | three times or more |
|--|------|------|-------|---------------------|
| pub | [] | [] | [] | [] |
| disco/night club | [] | [] | [] | [] |
| party | [] | [] | [] | [] |
| with friends (other than at pub/disco/party) | [] | [] | [] | [] |
| alone | [] | [] | [] | [] |
| with family | [] | [] | [] | [] |
| other (please specify) | [] | [] | [] | [] |

6 On average, how much money a week do you have to spend from earnings, pocket money, allowances etc.?
(Please choose one option)

less than £5 []

£5 - £10 []

£11 - £20 []

more than £20 []

7
In the last six months have you ever got drunk?

no, never []
yes, just once []
yes, two or more times []

8
Have you ever used a substance (other than alcohol or tobacco) to get "high"?

yes []
no []

if yes, please mark all that apply

solvents []
cannabis []
dance drugs []
other []

Section 2
(Please mark on a scale of 1 to 5. Answer all parts)

9
Looking to the years ahead, to what extent do you feel in control of your own future in terms of ...

	do not control own future				control your own future
	1	2	3	4	5
... being well off financially	[]	[]	[]	[]	[]
... becoming a parent	[]	[]	[]	[]	[]
... living with a partner	[]	[]	[]	[]	[]
... being healthy	[]	[]	[]	[]	[]
... moving out of the area	[]	[]	[]	[]	[]
... gaining good qualifications	[]	[]	[]	[]	[]
... getting a job	[]	[]	[]	[]	[]

10
Listed below are a number of potential hazards to your health.
How likely do you think it is that *your* health will be affected at some time by these hazards?

	not likely				very likely
	1	2	3	4	5
heart attack	[]	[]	[]	[]	[]
natural disaster	[]	[]	[]	[]	[]
drugs	[]	[]	[]	[]	[]
HIV/AIDS	[]	[]	[]	[]	[]
mental stress	[]	[]	[]	[]	[]
alcohol	[]	[]	[]	[]	[]
violent attack	[]	[]	[]	[]	[]
cancer	[]	[]	[]	[]	[]
traffic accident	[]	[]	[]	[]	[]
pollution	[]	[]	[]	[]	[]
eating disorder	[]	[]	[]	[]	[]
other (please specify)	[]	[]	[]	[]	[]
.....					

11
Rate the following factors in terms of their likely effect on *your* health

	no effect				large effect
	1	2	3	4	5
environment	[]	[]	[]	[]	[]
influence of friends	[]	[]	[]	[]	[]
money	[]	[]	[]	[]	[]
quality of medical care	[]	[]	[]	[]	[]
safe sex	[]	[]	[]	[]	[]
good fortune	[]	[]	[]	[]	[]
exercise	[]	[]	[]	[]	[]
your weight	[]	[]	[]	[]	[]
fate	[]	[]	[]	[]	[]
type of food you eat	[]	[]	[]	[]	[]
influence of parents	[]	[]	[]	[]	[]
positive approach to life	[]	[]	[]	[]	[]
amount of sleep	[]	[]	[]	[]	[]
God/spiritual beliefs	[]	[]	[]	[]	[]

12 Where do you feel you fit on the scales below?

	1	2	3	4	5	
cautious	[]	[]	[]	[]	[]	adventurous
like to go out	[]	[]	[]	[]	[]	like to stay home
serious	[]	[]	[]	[]	[]	easy going
fashion conscious	[]	[]	[]	[]	[]	not fashion conscious
short for my age	[]	[]	[]	[]	[]	tall for my age
sporty	[]	[]	[]	[]	[]	not sporty
fat	[]	[]	[]	[]	[]	thin
confident	[]	[]	[]	[]	[]	shy
healthy	[]	[]	[]	[]	[]	not healthy
like risks	[]	[]	[]	[]	[]	like safety
not popular	[]	[]	[]	[]	[]	popular

13 Listed below are a number of possible ambitions you may have. How important are they for you?

	not important 1	2	3	4	very important 5
looking attractive	[]	[]	[]	[]	[]
earning money	[]	[]	[]	[]	[]
academic success	[]	[]	[]	[]	[]
keeping healthy	[]	[]	[]	[]	[]
being with friends	[]	[]	[]	[]	[]
sporting success	[]	[]	[]	[]	[]
having a family	[]	[]	[]	[]	[]
other (please specify)	[]	[]	[]	[]	[]

Section 3

14 Since the age of 10 have you ever suffered an injury or illness serious enough for you to need to stay in hospital?

yes [] no []

If yes, what was the injury or illness?

15 Do you suffer from any medical condition which affects your well-being? (eg. asthma, diabetes, epilepsy)

yes [] no []

If yes, please specify

16 Since you were 10 years old has any member of your *close* family ...

	yes	no
... had a serious accident?	[]	[]
... had a serious illness?	[]	[]
... died?	[]	[]

17 Since you were 10 years old has any *close* friend ...

	yes	no
... had a serious accident?	[]	[]
... had a serious illness?	[]	[]
... died?	[]	[]

18 Have any of the following things had a marked impact on your willingness to take risks with your health?

	yes	no
illness/accident to yourself	[]	[]
accident/death/illness of a relative	[]	[]
accident/death/illness of someone else	[]	[]
witnessing a serious accident	[]	[]
health education at school/youth club	[]	[]
TV programme viewed at home	[]	[]
other (please specify)	[]	[]

Section 4

19 Gender

Male ☐ Female ☐

20 Age

13 years ☐ 14 years ☐ 15 years ☐
16 years ☐ 17 years ☐ 18 years ☐

21 In terms of ethnic origin would you regard yourself as ...

Black (African) ☐ Black (Caribbean) ☐ Black (Others) ☐ Indian ☐ Pakistani ☐
Bangladeshi ☐ White ☐ Chinese ☐ Other ☐

22 In terms of religion, which ONE of the following categories best describes you?

Hindu ☐ Jewish ☐ Other Christian (eg. Baptist) ☐
Sikh ☐ Christian (Church of England) ☐ Other religion ☐
Muslim ☐ Christian (Catholic) ☐ No religion ☐

23 Which ONE of the following best describes the place where you live?

city ☐ town ☐ village ☐ suburbs ☐

24 Do you intend to ... (please choose ONE option)

... leave full-time education at 16? ☐
... do a full-time training/vocational course at school or college? ☐
... leave education at 18/19 years after A levels/NVQs? ☐
... study for a degree at university or college? ☐
... other (please specify) ☐

25 Which ONE of the following categories best describes your father's job?

- factory work, technician, driver, farmworker, trader, supervisor, ☐
shop work, builder
- office work, wears collar and tie, teacher, professional, manager ☐
- not employed/retired ☐
- don't live with father ☐
- don't know ☐

26 Which ONE of the following categories best describes your mother's job?

- factory work, driver, farmworker, trader, supervisor, ☐
shop work, clerk, typist, cleaner
- manager, professional, teacher, nurse ☐
- not employed/retired ☐
- don't live with mother ☐
- don't know ☐

Thank you for completing this questionnaire

***Please write any further comments on the back of the instruction sheet
supplied with this questionnaire***

For office use only

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐
0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐
0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐
0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐

APPENDIX 4b

Focus Group Schedule

Introductions myself
 brief explanation of the research project
 guarantees of confidentiality
 chance to get their voice heard
 ask their names (and get them to make a name card)

Smoking

Trigger Results obtained in last year’s survey
 Do the findings seem plausible; what factors could
 account for the pattern of findings

Identification of smokers/ non-smokers in the group

Non-smokers: Is this a positive decision?
 Do you think you may smoke at some time in the future?
 What has influenced your attitude toward smoking?
 Prompts:
 • Critical incidents
 • Risks to health
 • Influence of parents
 • Influence of friends
 • Religion/ culture
 • Health education at school
 • Legal situation
 • Social life

Smokers: What has influenced your attitude toward smoking
 Prompts (as before)

Alcohol

Trigger Results from survey (frequency and drunkenness)
 Do the findings seem plausible; what factors could
 account for the pattern of findings

Identification of drinkers and non-drinkers in the group

Drinkers What has influenced your attitude toward drinking?

	Prompts (as before)
Non-drinkers	Is this a positive decision Do you think that you may drink in the future What has influenced your attitude toward alcohol Prompts (as before)
Illegal drugs	
Trigger	Results from the survey Do the findings seem plausible; what factors could account for the pattern of findings
Identification of those who have used an illicit substance and those who have not	
Non users	Is this a positive decision Do you think you might use drugs in the future What has influenced your attitudes towards drugs Prompts (as before)
Users	What has influenced your attitudes Prompts (as before)
Health education	
Trigger	results from survey Do the findings seem plausible; what factors could account for the pattern of findings
How much/ what type of health education on drugs have they been exposed to Positive and negative aspects	
Health Promotion	the influence of the school in general (policies, environment, ethos etc)

Health-Related Attitudes and Behaviour



**DE MONTFORT
UNIVERSITY
LEICESTER**

Interview Administration Procedure

Leicester Business School
Department of Public Policy and
Managerial Studies

Professor David Wilson BA BPhil PhD
Head of Department

Selection of students:

Selection criteria: (in order of priority)

- i) volunteers
- ii) mixture of boys and girls
- iii) ethnic mix (similar to that in the school as a whole)
- iv) mixture of ability
- v) willing to speak out and voice their opinions

Numbers: between 4 and 6. (definitely no more than 8)

Location:

To help the success of the interviews, which will be taped, we would be grateful if some room or private area could be organized which will be as free from interruption as is feasible to arrange and which is relatively soundproof.

Duration:

The interviews should last about 45 minutes.

Timing:

During scheduled lesson time.

Confidentiality:

This needs to be stressed when inviting people to participate. Only the researchers at De Montfort University will listen to the interviews. Participants will not need to give their names. Anonymity will be guaranteed. Publications arising from the research will not reveal the identity of the participants or the school.

<admin2.doc>

Thank you for your help in carrying out this research.

Prof Martyn Denscombe

Mrs Nicky Drucquer

TEXT BOUND INTO THE SPINE

Survey of drugs education policy in secondary phase schools.

Name of school/ college _____

Co-ordinators name/ position _____

Is your schools' drugs education policy?

Free-standing ☐ Part of a broader health ed. policy ☐ No formal policy ☐

When was the policy written/ last revised?

Pre spring 1995 ☐ Summer 1995 ☐ 1996/1997 ☐ 1997/1998 ☐

Are there plans to revise the policy during the current academic year?

Yes ☐ No ☐

On the grid below please indicate where drugs education (including work on other substances such as prescribed drugs, solvents, alcohol and tobacco) features in the curriculum.

Year	Science	Maths	English	Techno logy	Humani ties	R.E	P.E	P.S.E	Tutorial periods	Other (please state)
6										
7										
8										
9										
10										
11										

If the school uses other approaches, e.g. exhibitions/ assemblies, in relation to education on smoking, alcohol or illegal drugs please give brief details below. (Provide extra details on a further sheet, if wished.)

What proportion of teachers at the school would you estimate have been involved in drugs-related INSET?

0-24% ☐ 25-49% ☐ 50-74% ☐ 75-100% ☐

Does the school currently have a smoking policy? Yes ☐ No ☐

Does the school currently have a policy for dealing with drug-related incidents? Yes ☐ No ☐

1. Please ring the relevant position on the scale below to indicate the extent to which you would agree with the following statements in relation to the current situation in your school.

	Strongly Agree								Strongly Disagree
Drugs/ substance education has a strong presence within the curriculum of all pupils									
Concerted efforts are made to inform parents about the school's approach to drugs/substance education.									
Staff have access to good resources to support their teaching on drugs/substances									
The school places a high value on the active promotion of the mental, physical and social health of its pupils.									
The drugs education programme is closely monitored and students feedback is taken on board.									
Staff are confident with the teaching skills required to deliver the drugs/ substance education policy.									

12. Please state any significant factors, which, in your opinion, affect the implementation of the drugs education policy in your school.

13. Would you be interested in receiving further copies of our newsletter? Yes ☐ No ☐

14. Would you be interested in assisting us with a more in-depth study of the implementation and impact of drugs education in your school?

Yes ☐ Possibly ☐ Definitely not ☐

Thank you for completing this questionnaire. Please return (in the envelope provided) to:
Nicky Drucquer. Dept. of Public Policy. De Montfort University. Scraptoft Campus. Leics LE7 9SU

INTERVIEW SCHEDULE

Introduction

- Confidentiality
- Focus on drug-related health promotion in formal and informal curriculum

Organisation of drug education within the school (=legal and illegal drugs)

- In what subjects/ years does it feature in the curriculum
- Number of sessions devoted to it/ context
- Who delivers it
- Who co-ordinates it/ how is it co-ordinated

Background to the adoption of this model of approach

- Strengths (outside help, access to resources)
- Weaknesses (lack of time, willingness of staff, status in the eyes of pupils)

Aims of drug education TRIGGER

- Messages
- Methods
- Resources
- Scheme of work

Response to pupils preferences

- for information (accurate, balanced facts)
- for discussion (open, non-judgemental climate)
- for exposure to the experience of others
- ? for skills to resist peer-pressure

Support for substance education within informal curriculum

- Policies (development and implementation)
- School ethos (emphasis on academic standards/ coping with stress)
- Health promotion role of youth tutors?

REFERENCES

- Advisory Council for the Misuse of Drugs.(1984) *Prevention: Report of the ACMD*
London: HMSO
- Advisory Council for the Misuse of Drugs.(1993) *Drug Education in Schools: The Need for a New Impetus*. London: HMSO
- Allot, R.; Paxton, R. and Leonard, R.(1999)Drug education: a review of British Government policy and its effectiveness *Health Education Research*. 14 (4): 491-505
- Ashton, J. and Seymour, H.(1988) *The New Public Health* Milton Keynes: Open University Press
- Austin, E.W.(1995)Researching young audiences: developmental considerations in designing health messages In Mailbach, E. and Parrott, R.L. (eds)*Designing health Messages: Approaches form Communication Theory and Public Health*. Thousand Oaks, Capulet Sage
- Azjen, I.(1991)The theory of planned behaviour *Organisational Behaviour and Human Decision Processes* 50: 179-211
- Azjen, I. and Fishbein, M.(1980) *Understanding Attitudes and Predicting Social Behaviour* Englewood Cliffs, N.J: Prentice Hall
- Azjen. I.(1988) *Attitude. Personality and Behaviour* Milton Keynes: Open University Press
- Baggott, R.(1990) *Alcohol, Politics and Social Policy* Aldershot: Avebury/ Gower
- Baggott, R.(2000) *Public Health: Policy and Politics*. London: Macmillan
- Bagnall, G.(1991) *Educating Young Drinkers*. London; Tavistock/ Routledge
- Balding, J.(1995)Drugs: all our children are close to sources *Education and Health* 13 (2): 21-27
- Bandura, A. (1986) *Social Foundations of Thought and Action: A Social Cognitive Theory*. Englewood Cliffs, N.J: Prentice Hall.
- Bandura, A (1977)Self-efficacy: towards a unifying theory of behaviour change. *Psychological Review*. 84: 191-215.
- Bandy, P. and President, P.A.(1983)Recent literature on drug abuse prevention *Journal of Drug Education* 13 (3): 255-271

- Barrett, S. and Fudge, C. (eds).(1981) *Policy and Action*. London: Methuen.
- Barrett, S. and Hill, M.(1984)Policy Bargaining and structure in implementation theory: towards an integrated perspective. *Policy and Politics*. 12 (3): 219 -240
- Beattie, A.(1991)Knowledge and control in health promotion: a test case for social policy and social theory. In Gabe, J., Calnan, M. and Bury, M. (eds.)*The Sociology of the Health Service*. London: Routledge.
- Beattie, A.(1995)Evaluation in community development for health: an opportunity for dialogue, *Health Education Journal* 54: 465-471
- Beck, U.(1992) *Risk Society: Towards a New Modernity*. London: Sage
- Becker, M.H.(1974) *The Health Belief Model and Personal Health Behaviour* Thorofare, New Jersey: Slack
- Becker, M.H. and Maiman, L.A.(1975)Sociobehavioural determinants of compliance with health and medical care recommendations. *Medical Care*. 13: 10-24
- Bennet, P. and Murphy, S.(1997) *Psychology and Health Promotion* Buckingham: Open University Press
- Berlo, D. K; Lemwert, J.B. and Metz, R.J.(1969/70) Dimensions for evaluation the acceptability of message sources *Public Opinion Quarterley* 33: 563-576
- Berridge, V.(1998) *Opium and the People. Revised Edition*. London: Allen Lane.
- Bettinghaus, E.P.(1973) *Persuasive Communication (2nd edition)* New York: Holt, Reinhart and Winston
- Bolam, S.(1975)The management of educational change: towards a conceptual framework. In: Houghton, V., McHugh, R. and Morgan, C. eds*The Management of Organisations and Individuals* London: Open University Press
- Botvin, G.(1983) Prevention of adolescent substance use through the development of personal and social competence in Gynn, T (ed) *Drug Abuse Prevention Research* Rockville, Md: NIDA
- Botvin, G. and Dusenbury, L.(1989) Substance abuse prevention and the promotion of competence, in Bond, L. and Compas, B (eds) *Primary Prevention and Promotion in the Schools*. London: Sage

- Brewer, J. and Hunter, A.(1989) *Multimethod Research: A Synthesis of Styles*. Newbury Park, Ca: Sage.
- Bristol Education Committee (1944) *Education Committee Advisory Report on Health Education*. Bristol: BEC
- Browne, A. and Wildavsky, A.(1984)Should evaluation become implementation: In Pressman, J. and Wildavsky, A. (eds)*Implementation, 2nd edition* Berkeley: University of California Press
- Browne, A. and Wildavsky, A.(1987) *The Politics of Programme Evaluation*. Newbury Park, Ca: Sage
- Bunton, R.; Murphy, S. and Bennett,P.(1991)Theories of behaviour change and their use in health promotion: some neglected areas. *Health Education Research*. 6 (2): 153-162
- Butcher, J. (2000) *Summary of the Report on Consultations with Young People about Drug Education and Support* London: Drug Education Forum/ National Children's Bureau
- Cabinet Office.(2003) *The Magenta Book: A Guide to Policy Evaluation* London: Chief Social Researchers Office
- Cale, L.(1997)Health education in schools: in a state of good health? *International Journal of Health Education* 35 (2): 59-62
- Cannan, J. (1996) “‘One thing leads to another’: drinking, fighting and working class masculinities’, in M. Mac an Ghail (ed) *Understanding Masculinities*, Buckingham: Open University Press.
- Castell, R (1991) From dangerousness to risk. In Burchell, G., Gordon, C and Miller, P (eds) *The Foucault Effect: Studies in Governmentality*. London: Harvester Wheatsheaf
- Cm 1986(1992) *The Health of the Nation: A Strategy for Health in England*. London: HMSO
- Cm 2846(1995) *Tackling Drugs Together. A Strategy for England 1995-98*. London: HMSO
- Cm 3945(1998) *Tackling Drugs to Build a Better Britain. The Government's 10 Year Strategy*. London: Stationary Office
- Cm 4177(1998) *Smoking Kills*. London: Stationary Office.

- Coffield, F. and Gofton, L.(1994) *Drugs and Young People* London: Institute of Public Policy Research
- Coggans, N.(1998)Thirty years of drug education: whose learning curve? *Druglink* 13 (6): 12-14 London: Cabinet Office
- Coggans, N. and McKellar, S.(1994)Drug use amongst peers: peer pressure or peer preference? *Drugs: Education, Prevention and Policy*. 1: 15 -26
- Coggans, N. and Watson, J.(1995)Drug Education approaches, effectiveness and delivery. *Drugs: Education, Prevention and Policy*. 2 (3): 211-24.
- Cohen, J.(1992)Achieving a reduction in drug-related harm through education. In O'Hare, P.A., Matthews, A, Buning, E.C., and Drucker. E.*The Reduction of Drug-Related Harm*. London: Routledge.
- Cohen, J.(1996) Drugs in the classroom: politics, propoganda and censorship. *Druglink*. May/April. : 12-14
- Cohen, J.(2002)Just say - 'Oh no, not again' *Druglink* July/August: 13-14
- Collinson, M (1996) In search of the high life: drugs, crime, masculinities and consumption. *British Journal of Criminology*. 36 (3) 426-444
- Connor, M. and Norman, P (eds)(1996) *Predicting Health Behaviour*. Buckingham: Open University Press
- Davenport-Hines, R.(2001) *The Pursuit of Oblivion: A Social History of Drugs*. London: Pheonix Press
- Davies, P.(2004) Policy evaluation in the United Kingdom *KDI International Policy Evaluation Forum*. Seoul: May 19-21
- De Haes, W.(1987)Looking for effective drug education programmes: fifteen years exploration of the effects of different drug education programmes. *Health Education Research* 2 (4): 433-438
- Denscombe, M.(1992)'Its just another piece of school-work': The ethics of questionnaire research on pupils in school. *British Educational Research Journal*. 18 (2): 151-171.
- Denscombe, M.(1993)Personal health and the social psychology of risk taking. *Health Education Research*. 8 (4): 505-51

- Denscombe, M.(2000))Social conditions for stress: young people's experiences of doing GCSEs. *British Educational Research Journal* 26 (3): 358-374
- Denscombe, M.(2001)Uncertain identities and health risk-risking behaviour *British Journal of Sociology* 52 (1): 157-177
- Denscombe, M (2003) The Good Research Guide (2nd edition) Maidenhead: Open University Press
- Denscombe, M and Drucquer, N.(1999a)Critical incidents and invulnerability to risk: young people's experiences of serious health-related incidents and their willingness to take health risks. *Health, Risk and Society*. 1 (2): 195-207
- Denscombe, M. and Drucquer, N.(1999b) Uncertain identities and health risk-taking behaviour. *Occasional Paper 53*. Leicester: Business School : De Montfort University
- Denscombe, M. and Drucquer, N.(1999c) Peer group pressure, young people and smoking: new developments and policy implications. *Occasional Paper 54*. Leicester: Business School: De Montfort University
- Denscombe, M. and Drucquer, N.(2000)Diversity within ethnic groups: alcohol and tobacco consumption by young people in the East Midlands. *Health Education Journal*
- Department Education and Science (1986) *Education Support Grant Scheme: Action to Combat Drug Misuse. Circular 5185*, London: DES
- Department for Education.(1995a) *Circular Number 4/95: Drug Prevention in Schools*. DfE
- Department for Education (1995b) *A Digest of Education Resources for Schools* London: DfE
- Department for Education (1995c) *The National Curriculum*. London: HMSO
- Department for Education/ School Curriculum and Assessment Authority.(1995) *Drug Education: Curriculum Guidance for Schools*. DfEE/ SCAA
- Department for Education and Employment.(1998) *Protecting Young People: Good Practice in Drug Education and the Youth Service*. London: DfEE
- Department for Education and Employment(1999) *National Healthy School Standard: Guidance* London: Department for Education and Skills

- Department for Education and Employment (2002) *National Curriculum for England* London: DfEE
- Department for Education and Skills (2004a) *National Healthy School Standard: Drug Education (including alcohol and tobacco)* London: Health Development Agency
- Department for Education and Skills (2004b) *Drugs Guidance for Schools*. London: Department of Health
- Department of Health (1998) *Smoking Kills*. London: HMSO
- Department of Health (2004) *Alcohol Strategy* London: DH
- Dorn, N. (1983) *Alcohol, Youth and the State*. London: Croom Helm
- Dorn, N and South, N.(1985)Return of the topic. *Health Education Journal* 44 (4): 208-212
- Dorn, N and South, N. (eds) (1987) *A Land Fit for Heroin? Drug Policies, Prevention and Practice*. London: Macmillan
- Dorn, N. and Murji, K.(1992) *Drug Prevention: A Review of the English Language Literature*. ISDD Research Monograph 5. London: ISDD.
- Douglas, M. (1985) *Risk Acceptability According to the Social Sciences*. London: Routledge
- Douglas, M. (1992) *Risk and Blame: Essays in Cultural Theory*. London: Routledge.
- Drug Education Forum(1998) Belief statement *Drug Education Matters 1*: London: Drug Education Forum
- Dunsire, A.(1978) *Implementation in a Bureaucracy*. Oxford: Martin Robertson
- Edwards, G.;Arif, A. and Jaffe, J. eds(1983) *Drug Use and Misuse: Cultural Perspectives*. Beckenham: Croom Helm/ World Health Organisation.
- Eiser, J.R. et al (1991)Adolescent health behaviour and similarity attraction: friends share smoking habits (really), but much else besides. *British Journal of Social Psychology* 30: 339-348
- Elkind, D.(1967)Egocentrism in adolescence *Child Development* 30: 1025-1034
- Elmore, R.(1978)Organisational models of social programme implementation *Public policy* 26: 185 -228
- Engels, R.(1997)Homogemeity og cigarette smoking within peer groups: influence or selection? *Health Education and Behaviour* 24 (6): 801-811

- European Centre for Addiction Studies(2002) *Drug-related Deaths Reported by Coroners in England and Wales*. London: ECAS
- Everitt, A(1995)Values and evidence in evaluating community health projects *Critical Public Health* 6 (3): 56-65
- Everitt, A. and Hardiker, P.(1996) *Evaluating For Good Practice*. London: Macmillan.
- Festinger, L.(1957) *A Theory of Cognitive Dissonance*. Stanford; University Press.
- Fishbein and Ajzen(1975) *Belief, Attitude, Intention and Behaviour* New York: Wiley
- Fitzgerald, N; Stewart, D., Machie, C.A.(2002)A qualitative study of drug education in secondary schools in North-East Scotland *Drugs: Education, Prevention and Policy* 9 (3): 253-265
- Ford, C.(1995)When it's too late to say no *Health Matters* 24: 15-16
- Foucault, M (1991) Governmentality. In Burchell, G.,Gordon, C and Miller, P (eds) *The Foucault Effect: Studies in Governmentality*. London: Harvester Wheatsheaf
- France, A.(2000)Towards a sociological understanding of youth and their risk-taking *Journal of Youth Studies* 3 (3): 317-331
- Frankham.(1998) Peer education: the unauthorised version *British Education Research Journal* 24 (2): 179-196
- Fraser, E.(1996)How effective are effectiveness reviews? *Health Education Journal* 55 : 359-362
- Friedman, L.,Lichenstein, E. and Biglan, A(1985)Smoking onset amongst teens: an empirical analysis of initial situations. *Addictive Behaviour* 10: 1-13
- Fullan, M.(1982)Research into educational innovation. In Gray, H.L. (ed) *The Management of Educational Institutions*. London: Falmer Press
- Giddens, A. (1990) *The Consequences of Modernity*. Cambridge: Polity Press.
- Giddens, A.(1991) *Modernity and Self-Identity* Cambridge: Polity Press
- Glaser, B. and Strauss, A.(1967) *The Discovery of Grounded Theory*. Chicago: Aldine.
- Gordon, K.(1991)Improving practice through illuminative evaluation *Social Sciences Review*. 10: 65-377
- Graham, H.(1984) *Women, Health and the Family*. Brighton: Harvester Wheatsheaf.
- Guba, E. and Lincoln, Y.(1989) *Fourth Generation Evaluation*. Newbury Park: Sage.

- Guba, E.G. and Lincoln, Y.S.(1981) *Effective Evaluation*. San Francisco: Jossey Bass
- Gunn, L.(1978)Why is implementation so difficult? *Managemant Services in Government* 33 : 169-77
- Hale, J.L. and Dillard, J.P.(1995)Fear appeals in health promotion campaigns: too much, too little or just right? chapter 4 in Mailbach, E. and Parrott, R.L. (eds) *Designing Health Messages. Approaches form Communication Theory and Public Health Practice*. Thousand Oaks, Ca: Sage
- Hansen, W. and Mc Neal, R.(1999)Drug education practice: results of an observational study. *Health Education Research* 14 (1): 85-97
- Hansen, W.B.(1992)School-based substance abuse prevention: a review of the state of art in the curriculum. 1980-1990. *Health Education Research*. 7 : 403-430.
- Hanson, D.J.(1982)The effectiveness of alcohol and drug education. *Journal of Alcohol and Drug Education*. 27 (2): 1-13
- Harding, L.F.(1991) *Perspectives in Childcare Policy*. London: Longman
- Hargreaves, J. (1997) Women's boxing and related activities: introducing images and meanings. *Body and Society* 3 (4) 33-50
- Harrison, L. and Means, R(1986)Implementing a holistic approach to alcohol education *Health Education Journal* 45 (3): 132-136
- Hastings, G. and Stead, M.(1999) *Using the Media in Drug Prevention*. Paper 19 London: Home Office
- Hazel, N.(1996)Elicitation techniques with young children. *Social Research Update*. 12
- Health Education Authority/ British Market Research Bureau(1997) *Young People and Health: the Health Behaviour of School-aged Children*. London: HEA
- Health Educaton Authority.(1998) *Young People, Alcohol and Their Social World*. London: H.E.A.
- Hepworth, J.(1997)Evaluation in health outcomes research: linking theories, methodologies and practice in health promotion. *Health Promotion International* 12 (3): 233-238
- Hill, M.(1998)Implementation theory: yesterday's issue? *Policy and Practice* 25 (4): 375-385

- Hjern, B.; Hanf, B. and Porter, D.(1978)Local networks of manpower training in the federal Republic of Germany and Sweden, in Hanf, K. and Scharpf. (eds) *Interorganisational Policy Making: Limits to Coordination and Central Control* London; Sage
- HM Treasury (2003) *The Green Book: A Guide to Appraisal and Evaluation* London: HM Treasury
- Holland, J. et al.(1992) Pressure, resistance, empowerment: young women and the negotiation of safe sex. In Aggleton, P.; Davis, P. and Hart, G. (eds)*AIDS: Rights, Risk and Reason*. London: Falmer Press.
- Home Affairs Select Committee(2002)3rd Report *The Government's Drug Policy: Is it Working?* Stationary Office
- Hood, C.C.(1976) *The Limits of Administration*. London: John Wiley
- Hopson, B. and Scaly, M.(1980, 1982, 1985, 1985, 1987) *Lifeskills Teaching Programme 1, 2, 3 and 4*. Leeds: Lifeskills Associates.
- Hovland, C.I. And Weiss, W.(1951)The influence of source credibility on communication effectiveness *Public Opinion Quarterley* 15 : 635 -50
- Hovland, C.I., Janis, I.L. and Kelley, H.H.(1953) *Communication and Persuasion* New Haven, CT: Yale University Press
- Howe, K.R.(1988)Against the qualitative-quantitative incompatibility thesis or dogmas die hard. *Educational Researcher*. 17: 10-16
- Howlett, M. and Ramesh, M.(1995) Chapter 8 in *Studying Public Policy*. Oxford: Oxford University Press
- ISDD Research and Development Unit(1984) 3rd revision *Drugs in Health Education: Trends and Issues*. London: ISDD
- Ives, R. and Clements, C.(1996) Drugs education in schools: a review. *Children in Society*. 10 (2): 14-27.
- Jack, M. S.(1989)Personal fable: a potential explanation for risk-taking behaviour in adolescents. *Journal of Paediatric Nursing*. 4 (5): 334-338
- Janz, N. K. and Becker, M.H.(1984)The health belief model: a decade later. *Health Education Quarterly*. 11: 1-46

- Jeffrey, W. J.(1989) Risk behaviours and health; contrasting individual and population perspectives. *American Psychologist* 44 (9): 1194-1202
- Jick, T.D.(1979) Mixing qualitative and qualitative methods. Triangulation in action. *Administrative Science Quarterly*. 24: 602-611
- Joseph Rowntree Foundation(1997) *Young People and Drugs*. York: Joseph Rowntree Foundation
- Kaneko, M (1999)A methodological inquiry into the evaluation of smoking cessation programmes *Health Education Research* 14 (3): 433-441
- Kirk, J. and Miller, M.(1986) *Reliability and Validity in Social Research*. Beverley Hills, Ca: Sage.
- Labonte, R. and Robertson, A.(1996)Delivering the goods, showing our stuff: the case for a constructivist paradigm for health promotion research and practice. *Health Education Quarterly*. 23 (4): 1443-1447.
- Layder, D. (1990) *The Realist Image in Social Science*. London: Macmillan
- Layder, D. (1993) *New Strategies in Social Research*. Cambridge: Polity Press
- Layder, D. (1997) *Modern Social Theory: Key Debates and New Directions*. London: University College Press.
- Layder, D.(1998) *Sociological Practice: Linking Theory and Social Research*. London: Sage
- Leicestershire County Council Education Department (1995) *Advice on Drug Education and Handling Drug Related Incidents* Policy Guidelines Series Leicestershire: County Hall
- Leicestershire Health Promotion Centre(1996) *A Healthy Investment: A Survey of Health Education Practice in Leicestershire Schools and Colleges* Leicestershire HPC
- Leventhal, H.(1970)Findings and theory in the study of fear communications, in L. Berkowitz (ed.) *Advances in Social Psychology*. New York: Academic Press.
- Leventhal, H. and Cleary, P.D.(1980)The smoking problem: a review of the research and theory in behavioural risk modification *Psychological Bulletin* 88 (2): 370 -405
- Lewis, A.(1992)Group interviews as a research tool. *British Educational Research Journal*. 18 (4): 413-421.

- Lewis, D.(1993)Oh for those halcyon days! A review of the development of school health education over 50 years *Health Education Journal*.52 (3): 161-170
- Lewis, J. and Flynn, R.(1978) *Urban and Regional Planning Policies: A Feasibility Study*. London: Department of the Environment
- Lewis, J. and Flynn, R.(1979)The implementation of urban and regional planning policies. *Policy and Politics*. 7: 123-142.
- Lincoln, Y. and Guba, E.G.(1985) *Naturalistic Enquiry*. Newbury Park, Ca: Sage.
- Lipsky, M.(1971) Street-level bureaucracy and the analysis of urban reform. *Management service in Government* 33: 169 -77
- Lloyd, B. and Lucas, K.(1998) *Smoking ion Adolescence: Images and Identities*. London: Routledge.
- Lynagh, M., Schofield, M.J. and Sanson-Fisher, R. W.(1997)School health promotion programs over the last decade: a review of the smoking, alcohol and solar protection literature. *Health Promotion international*. 12 (1): 43-60
- Lyng, S. (1990) Edgework: a social psychological analysis of voluntary risk taking. *American Journal of Sociology* 95 (4) 851-886
- Lupton, D (1999) *Risk*. London: Routledge.
- Macdonald, G; Veen, C. and Tones, K.(1996) Evidence for success in health promotion: suggestions for improvement *Health Education Research* 11 (3): 367-376
- Macdonald, G.(2000)A new evidence framework for health promotion practice *Health Education Journal* 59: 3-11
- Majone, G. and Wildanvsky, A.(1978)Implementation as Evolution, in Freeman, H. (ed) *Policy Studies Review Annual*. California: Sage.
- May, C.(1991)Research on alcohol education for young people; a critical review of the literature. *Health Education Journal*. 50 4: 195-199
- McGuire, P(1964)Inducing resistance to persuasion In Berkewitz, L. (ed)*Advances in Experimental Psychology*: 192-229 New York: Academic Press
- Means, R. and Smith, R.(1988)Implementing a pluralistic approach to evalaution inhealth education *Policy and Politics* 16 (1): 17-28

- Measham, F., Newcombe, R. and Parker, H.(1994)The normalisation of recreational drug use amongst young people in North-West England. *British Journal of Sociology*. 45 (2): 287-312.
- Miles, M. and Huberman, A.(1994) *Qualitative Data Analysis*. Thousand Oaks, Ca: Sage.
- Miller, P.C. and Plant, M.(1996) Drinking, smoking and illicit drug use among 15-16 year olds in the United Kingdom. *British Medical Journal*. 31: 394-397.
- Milward, L. et al(2004) *Evidence for Effective Drug Prevention in Young People: A Summary of Findings Arising from Research Activity To Date*. London: Health Development Agency.
- Morrow. V. and Richards, V.(1996)The ethics of social research with children. *Children and Society*. 10 : 90-105.
- Musto, D.F.(1997)Alcohol control in historical perspective.In Plant, M. et al (eds)*Alcohol; Minimising the Harm. What works?* London: Free Association Books.
- Naidoo, J and Wells, J(2000)2nd edition *Health Promotion: Foundations for Practice. Second edition*. London: Elsevier Science
- Nettleton, S. and Bunton, R.(1995)Sociological critiques of health promotion. In Bunton, R.,Nettleton, S. and Burrows.(eds)*The Sociology of Health Promotion* London: Routledge
- NHS Centre for Reviews and Dissemination(1999)Preventing the uptake of smoking in young people *Effective Health Care* 5 (5)
- Nutbeam, D.(1996) Achieving 'best practice' in health promotion: improving the fit between research and practice *Health Education Research* 11 (3): 317-326
- Nutbeam, D.(1998) Evaluating health promotion - progress, problems and solutions. *Health Promotion International*. 13 (1): 27-44
- Nutbeam, D and Harris, E.(1999) *Theory in a Nutshell. A Guide to Health Promotion Theory*. Australia: McGraw
- O' Connor, L et al (1998) Drugs policies in schools: moving from statements of intent to effective action, in O'Connor, L; O'Connor, D and Best, R. (eds)*Drugs: Partnership, Policy, Prevention and Education* London: Cassell
- Oakley, A.,Bendlelow, G., Barnes, J., Buchanana,M. and Husain, N,(1995)Health and cancer prevention *British Medical Journal* 310: 1029-1033

- Oakley, A. and Fullerton, D. (1995) *Young People and Smoking*. London: London University (Social Science Research Unit)
- Office for Standards in Education (1997) *Drug Education in Schools*. London: OFSTED
- Office for Standards in Education(2002) *Drug Education In Schools: an Update* London: OFSTED
- Parker, H., Aldbridge, J. and Measham, F. (1998) *Illegal Leisure: The Normalisation of Adolescent Recreational Drug Use*. London: Routledge.
- Parlett, M. and Hamilton, D.(1976)Evaluation as illumination: a new approach to the study of innovatory programs. Glass, G.V. (ed) *Evaluation studies Review Annual 1979*. California; Sage.
- Parsons, C.; Stears, D.and Thomas, C.(1995)The health promoting school in Europe: conceptualising and evaluating the change. *Health Education Journal*. 55, : 311-321. San Diego: Academic Press.
- Parsons, W.(1995) *Public Policy: An Introduction to the Theory and Practice of Policy Analysis*. Cheltenham: Edward Elgar.
- Patton, M.D.(1988) *How to Use Qualitative Methods in Evaluation*. London: Sage.
- Pawson, R. and Tilley, N.(1997) *Realist Evaluation*. London: Sage
- Perri 6., Jupp, B., Perry, H. and Lasky, K.(1997) *The Substance of Youth: The Role of Drugs in Young Peoples' Lives Today*. York: Joseph Rowntree Foundation.
- Petty, R. and Cacioppo. J.(1986)The elaboration likelihood model of persuasion In L. Berkowitz (ed) *Advances in Experimental Psychology* 19 Orlando: Academic Press
- Plant, M. and Plant, M.(1997)Alcohol education and harm minimisation. In Plant, M.; Single, E. and Stockwell, T. (eds) London: Free Association Books.
- Plant, M. and Plant. M.(1992) *Risk-Takers: Alcohol, Drugs, Sex and Youth*. London: Routledge.
- Polllitt, C.(1996) Models of policy implementation in the NHS In (eds)
- Predegast, S.(1994) *'Time to Grow Up'. Girls' Experiences of Menstruation in School*. London: Family Planning Association
- Pressman, J. and Wildavsky, A.(1973) *Implementation* Berkeley: University of California Press

- Prime Minister's Strategy Unit (2004) *Alcohol Harm Reduction Strategy for England*. Stationary Office
- Ramsey, M. et al (2001) *Drug Use Declared in 2000: Results for the British Crime Survey* London: Home Office
- Ray, M.L. and Wilkie, W.L.(1970) Fear: the potential of an appeal neglected by marketing. *Journal of Marketing* 34: 54-62
- Rogers, R.W.(1975) A protection motivation theory of fear appeals and attitude change *Journal of Psychology* 9: 93-114
- Roker, D. and Coleman, J.(1997) Education and advice about illegal drugs: what do young people want? *Drugs Education, Prevention and Policy*. 4 (1): 53-65
- Rosenstock(1966) 'Why people uses health services' *Millbank Memorial Fund Quarterley* 44: 94-124
- Rotter, J. B.(1966) Generalised expectancies for internal versus internal control of reinforcement. *Psychological Monographs*. 80 (1) no. 609.
- Rudat, K.(1992) *Tomorrow's Young Adults*. London: HEA.
- Sabatier, P.A. and Maziman, D.(1979) The conditions of effective implementation *Policy Analysis* 5: 481-504
- Schools Council/ HEC Project(1977) *Health Education 5-13* London: Nelson
- Schools Council/ HEC Project(1982) *Health Education 13-18* London: Forbes
- SCODA(1998b) *The Right Responses: Managing and Making Policy for Drug-related Incidents in Schools*. London: SCODA (now DrugScope)
- SCODA(1999) *The Right Approach: Quality Standards in Drug Education*. London: SCODA (now DrugScope)
- SCODA(1998a) *The Right Choice: Guidance on Selecting Drug education Materials for Schools*. London: SCODA (now DrugScope)
- Silverman, D.(1993) *Interpreting Quantitative Data: Methods for analysing Talk, Texts and Interaction*. Thousand Oaks, Ca: Sage.
- Single et al.(1975) The reliability and validity of drug use response in a large longitudinal study *Journal of Drug Issues*. 5: 426-433

- Smith, G. and Cantley, C.(1985) *Assessing Health Care: a Study of Organisational Evaluation*. Milton Keynes: Open University Press
- Social Research Association.(1989) *Ethical Guidelines: SRA Handbook*. London: Social Research Association.
- Stake, R.(1995) *The Art of Case study Research*. Thousand Oaks, Ca: Sage.
- Stears, D.; Clift, S. and Blackman, S.(1995) Health, sex and drug education: rhetoric and reality. In Ahier, J. and Ross, A. (eds)*The Social Subjects within the Curriculum*. Lewis: Falmer.
- Stranger, M. (1999) 'The aesthetics of risk: a study of surfing' *International Review of the Sociology of Sport*, 34 (3): 265-76
- Strauss, A. and Corbin, J.(1990) *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. London: Sage.
- Sutherland, I.(1979) Health education, the school system and the young, in: I, Sutherland (ed)*Health Education Perspectives and Choices*. London: Unwin.
- Swaddi, H.(1998)Drugs and substance use among 3,333 London adolescents. *British Journal of Addiction*. 83: 935-942.
- TACADE(1986) *Skills for Adolescence Project*. Ohio: Quest International Columbus
- Tashakkori, A. and Teddlie, C.(1998) *Mixed Methodology. Combining Qualitative and Quantitative Approaches*. London: Sage.
- Thomas, P. and Palfrey, C.(1996)Evaluation: a stake-holder-focussed criteria *Social Policy and Administration*. 30 (2): 125-142.
- Tilford, S.(2000) Evidence-based health promotion *Health Education Research* 15 (6): 659-663
- Tilley, N.(1993 a)Understanding Car Parks, Crime and CCTV. *Crime Prevention Unit Paper*, 38. London: Home Office
- Tilley, N.(1993 b)The Prevention of Crime against Small Businesses: the Safer Cities Experience. *Crime Prevention Unit Paper* 47, London: Home Office
- Tobler, K. and Stratton, H.(1997)Effectiveness of school-based drug prevention programmes: a meta analysis of the research. *Journal of Primary Prevention*. 18 (1): 71-128

- Tones, K.(1981)Health education: prevention or subversion? *Journal of the Royal Society for Health*. 3 : 114-117.
- Tones, K.(1987) Devising strategies for preventing drug misuse: the role of the Health Action Model. *Health Education Research*. 2 (4): 305-317.
- Tones, K.(1996)The health promoting school: some reflections on evalaution. *Health Education Research* 11 (4):i-viii
- Tones, K and Tilford, S.(2001)3rd edition *Health Education: Effectiveness, Efficiency, Equity*. 2nd edition. London: Nelson Thornes
- Tones, K and Green, J (2004) *Health Promotion: Planning and Strategies*. London: Sage
- Tulloch, J. and Lupton, D (2003) Risk and Everyday Life. London: Sage.
- Van Meter, D. and Van Horn, C.(1975)The policy implementation process: a conceptual framework. *Administration and Society*. 6: 445-88
- Walsh, I.(1993) *Trainspotting*. London: Minerva
- Wetherley, R. and Lipsky, M.(1977)Street-level bureaucrats and institutional innovation: implementing special educational reform. *Harvard Educational Review* 47 (2): 171-97
- White, D. and Pitts, M.(1997) *Health Promotion with Young People for the Prevention of Substance Misuse*. London: Health Education Authority
- Whitehead, M(1995)Evidence-based health education. *Health Education Journal*. 55: 1-2
- World Health Organisation(1999) *Health Promotion Evaluation: Recommendations to Policymakers*. Copenhagen: WHO
- World Health Organisation(1993) *The European Network of Healthy Schools*. Copenhagen: WHO
- World Health Organisation.(1986) *Ottawa Charter for Health Promotion*. Geneva: WHO
- Yin, R.(1994) *Case Study Research: Design and Methods*. 2nd edition. Newbury Park, Ca: Sage